Physician /Medical Examiner	4
	L
	1

Director

permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or iteme 23a or 28e-f ehow eny injury or other traumatic event, the Modical Examinar must be notified at ODEs.

SIMMS, JOAN Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	1 - Stata Registrar						Cer	tificat	e of l	Death	7		Rag.	No.) 0	00	001
	1. Decedent's Name	(First, Middle	e, Last)									2. Date of De Month		Day	Year	3. Ti	me of Death
n al		Joan	Ε.	Simn	ns							Octobe			2005	1	0:45a M
er	4a. Fecility Name (II GREATER	BALTI	_			CENTE	R	TOW	SON	Location					ity of Death	1	
	5. Social Security N 213-34-7	522	6. Sex 1 ☐ M	2 汉 F		ln yrs. last 68	birthday) Yrs.	If Under Months		If Under Hours	Min,	8. Date of Bir (Month, Da	iy. Ye	ar) .937	Cot	place (Sintry) ylan	tate or Foreign
	Usual Residence of 10a. State	10b. County			11	0c. City, T	own or Lo	cation								10d. Insi	de City Limits
ctor	Md.	Balti	imore				ltimo										Yes 2 No
ai Dire	10e. Street and Num	_{nber} en Cour	^t					10f. Zip		1234			10g.	Citizen o	of What Cou US	Vi.	
Completed by Funeral Director	11. Marital Status 1 Never Marri 3 Widowed	_	ried	Was Dec Armed Fo 1 Yes If Yes, Gi Year or D	2 XINo ive	er in U.S.	11	Was Deced I Yes, sped I □ Yes	cify Cuba	ispanic Oi n, Mexica Specify	in, Puerto	ocify Yes or No Rican, etc.))-		ace - Amer lack, White cify:		
pletec	(Spec.	15. Deceden	t's Educat st grade o	on ompleted) College (1	6a. Deced (Give		rk done d	turing mos	st of worki	ng	16b	. Kind of	Business/li	ndustry	
ĕ	Ciomontary/coco	110219 (5-12)			+		School	ol Te	ache	r				Educ	ation		
Be	17. Father's Name (First, Middle,	Last)							18. Moth	er's Name	(First, Middle	Maio	len Sum	ame)		-
P	Walter A	Atkinso	n							E. 1	Doris	Voltz					
	19a. Informant's Na					1	19b. Mailin	g Address	(Street a	and Numb	er or Rura	l Route Numbe	er, Ci	ty or Tow	n, State, Zi	ip Code)	
	Mr. John		Jr.,	/ Son			2.50			Rd.		e Hall,					
	20a. Method of Disp 1 X Burial 2 (4 ☐ Donation	Cremation		oval from		сете	e of Dispos etery, crem WOOd	natory or o	ther plac	′ 1	11-5-	05			n∙City or T More,		ate
	21. Signature of Fu	reral Service	Licensee	1			22	. Name ar Ru T N	d Address CK T	s of Facil OWSOI	n Fun	eral Ho	ome Md	, In	C.		
Medicai Examiner	23a. Part1. Enter the shock, or hear Immediate Cause (disease or condition resulting in death) Sequentially list confiance, each grade cause. Enter Unde Cause (Disease or that initiated events resulting in death) L	nditions,	a b cd.	Due to	or as a control of the second	e death. [OSUS consequent onsequent	ce of): (CY) ce of):		e of dyin							Approx Interva Onset	ximate al Between and Death
by Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months?	23c.	1☐Live t	oirth 2 [nant at tim	pregnancy Fetal death	ath 3 🗌	Ectopic pr Other (sp						1	Date of delivership	very Day	Year
	Part II. Other signifi	icant condition	ons contrib	uting to d	leath but r	not resultin	g in the ur	nderlying c	ause give	n in Part	1.	23e. Did t	,	co use co 2 □ No			e of death?
Completed												24a. Was autor perfo		2	prior to co death?	opsy lind ompletion 2 \(\subseteq \)	dings available of cause of
Be	25. Was case referrence examiner?	/		oital: %	,				0#		e of Death	(Check only o	one)				
. To	1 Tes 227. Manner of Death		Hosp		Inpatient		Outpatien			4 🗆 14		ne 5 Resid				ify)	
Medical Certification:	1 Natural 2 Accident 3 Suicide	5 Pendin investig 6 Could i	gation not be		ith, Day Y	ear)	b. Time of Injury	М		at ? Yes 2 □]No	28d. Describe				ral Route	Number
Certi	4 Homicide	determ		build	ing, etc. (Specify)						City or Tox	wn, St	ate)			
edica	29a. Certifier (Check only one)	2 Madical	g Physici Examiner	On the b	e best of n asis of ex iner stated	amination	dge, death and/or inv	occurred restigation	at the tim , in my of	e, date a pinion, de	nd place, a ath occurre	and due to the ad at the time,	date	e(s) and r and place	nanner as e, and due	stated. to the car	use(s)
Σ	29b. Signature and	title of certifie	10		00			290	. License	number	0 0		29d.	Date sign	ned (Month	. Day, Ye	ar)
	m	ach	100	nel	W.		MI)	DO	050	tot	2		10/	31/0	5	
67	30. Name and address 656 31. Date liled (Mont	9 1	ho comp	has	125	St	a) (Type, I	Print)	60	1 K	1V-10	lest	To	TWS.	on N	100	21204
e Ir	N. Date filed (Mont	ÖV 0 3	2005	1000	negistrar's	Signature	Service Contract of the Contra	-0.3									

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State Registrar

State of Maryland / Department of Health and Mental Hygiene 15 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 805, M **Physician** Frances Leola Schreiber /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Stella Maris Baltimore Timonium If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 29, 1912 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Min. Days Hours 1 □ M 2 🖸 F Maryland 214-44-3760 93 Yrs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. or 16 markad other than "netural", or Items 23e or 28e-f show 10d. Inside City Limits 10a. State 10c. City. Town or Location 10b. County 7 is markad other than "netural", or items 23e or 28a-f show traumatic avant, the Modical Examinar must be motified at 1 Tes 2 No Director MD Baltimore Parkville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2610 Wentworth Road 21234 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Hall Estelle Alfred Sadie Chenworth ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2:
Department of Health at
Importent: If itam 27 Is
any injury or other trau 2209 Aquilas Delight, Fallston, MD Wayne Schreiber-son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley 11/2/05 Timonium, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Livinsee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of deing, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death DE NI Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a equence of): r/griose/2 20 sis **Examiner** Sequentially list conditions, Due to (or as a consequence of) dany leading to immedicause. Enter Underlying Cause (Disease or injury burial-transit Exami ding physician and that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physiclan/Medlcal as the l IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten 3 Ectopic pregnancy Day Month Year in the past 12 months? 4 Pregnant at time of death ned by the at detached for 5 Other (specify) 1 ☐ Yes 2 ☑ No Division of Vital Records, P.O. 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Noknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has 2 🗆 No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: As Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes _2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred To the Hospital or Attending | within 24 hours after death. To tha Funaral Diractor: After 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature itle of certifier 29c. License number 05 30. Name and address of perfor who completed cause of death (Item 23a) (Type, Print) 10 32. Registrar's Signature 31. Date filed (Month, Day, Year) porte State 3 2005 Registrar

Please Type of Print in Black indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 05 35503 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year 5:50 AM Rudu 02 200 /Medical 4a. Facility Name (If not institution, give street and number) Baltimore M. D

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Day
Hours Min. 4b. City, Town, or Location of Death 4c. County of Death Examiner SAHC 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** -2576 10M 20 F 5 52 Yrs Director Usual Residence of Decedent permit. Peges 1 and 2 should be tiled within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ~ ... any injury or other traumatic even. 10h. County 10a State 10c. City, Town or Locat 10d. Inside City Limits Maryland 1 □ yes 2 □ No Be Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 905 Was Decedent Ev Armed Forces? 1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubap Mexican, Puerto Rican, etc.) American Indian, 14. Race Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) . Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) aborer NOWN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Harrison ျှ MoHe recon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mitt Son MADR 20a. Method of Disposition 20b. Place of Disposition (Name of Date Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1190 21. Signature of Funeral Service License 22. Name and Address of 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
5 Month Do not enter the mode of dying, such as cardia respiratory arrest Immediate Cause (Final **Physician** arcinoma disease or condition resulting in death) ancreation /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner inding physicien and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown 23d. Date of delivery been signed by the atten should be detached for u 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 robably 4 \(\subset Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificete 2 No 1 Yes 1 ☐ Yes Division of Vital 2 No To the Hospitel or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this many 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one, 2010 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 🗌 Yes 2 ER/Outpatient 3□ DOA filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Dux Alebrahim 2438528 102/2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (0 Baltimore MD

State Registrar Basel

31. Date filed (Month, Day, Year)

Alebrahim

2005

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3034 Bero

32. Registrar's Signature

			1 - For State Registrar	State of Maryland		artment of H		i Mental Hy	giene Reg. No. 0 0	5	35504
	Physici		1. Decedent's Name (First, Middle, La Cliarles	st) Vidno	ovic			2. Date of De Month Oct 2	Day	Year	3. Time of Death 3:10 P M
	/Medic Examin		4a. Fecility Name (If not institution, giv Manor Care Nurs:			4b. City, Town, or			4c. County	of Death	George's
	Funeral Director		5. Social Security Number 6. S 189 10 4362	7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		ay, Year)	Coun	lace (State or Foreign htty) sylvania
	Manyland -f show fied at	tor	10a. State 10b. County	ce George's Dis		cation Heights				1	0d. Inside City Limits 1 ☐ Yes XX No
3	With the	i Director	10e. Street and Number 1923 Brewton	Street		10f. Zip Code	20747		10g. Citizen of W		-
9	permit raggs I and 2 should be lied within 7 a hours arise death with the maryland important of Heelth and Mential Hyglene. Insportant: If time 27 is marked other then "neturel; or items 23e or 28e-f show eny injury or other traumatic event, it a Madical Examinar must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married XX Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No WW I If Yes, Give		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2∑∑No	ispanic Origin? In, Mexican, Pu Specify:	(Specify Yes or Ne erto Rican, etc.)		e - Americ k, White,	an Indian,
20-613	on /z nour en "neturel Medical Ex	Completed b	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual Occup. kind of work done o DO NOT use retired	during most of v	vorking	16b. Kind of Bu	siness/Ind	
4	Hygien ther th		12 17. Father's Name (First, Middle, Last,	4	Mana	ger	18. Mother's N	lame (First, Middle	Federal		ernment
y a	Mental Arked o	To Be	Elijo Vidnovi	ics				ia Vidnov			
Ma	olth and 27 is m		19a. Informant's Name/Relationship (Helen E. Vidnov			ng Address (Street a Brewton					Code) 20747
. ביים	iges rail of of Her or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State cem	netery, cren	sition (Name of natory or other place	1	Date	20c. Location -	City or To	wn, State
Dailli	Dennit ra Departmer important eny injury		4 Donation 5 Other (Specif	nsee Mooas7	22	matory (2.Name and Addres 1d Alexa	ss of Facility L	ee Fune	ral Hom	ie,]	Maryland Inc 6633
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death.						on,	MD 20735 Approximate Interval Between
F	nysician /Medical		Immediate Cause (Final disease or condition resulting in death)	aCongesti		eart Fa	ilure				Onset and Death
	Examiner	er	Sequentially list conditions,	b. Coronary Due to (or as a consequent	Art	ery Dise	ease				
	cate be executed bhysicien and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Hyperlip:	idem	ia					
00.70	physicien the buris	licai		d							
O. DOX .	Ine law requires thet the beath certificate be executed at the best signed by the attending physicien and page 2 should be deteched for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnanc 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	eath 3	Ectopic pregnancy Other (specify)			23d. Date Mor	e of delive	ry Day Year
L épu	quires iner in signed by uld be dete	þ	Part II. Other significant conditions of	contributing to death but not resulti	ing in the u	nderlying cause give	en in Part I.				e cause of death?
י הפכי	ne law requir ate hes been si page 2 should	Completed						24a. Was auto perfe	psy p ormed? d	rior to con leath?	osy findings available npletion of cause of
5 :	certific rector,	Be	25. Was case relerred to medical examiner?	Hospital:		Othe	ar	eath (Check only			
5 :	To the footballs for Attending Physician. The lat within 24 hours elfeath. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2.	ıtlon: To	1 ☐ Yes 2/☐No 27. Manner of Death 1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	28a Date of Injury (Month, Day Year)	8b. Time of Injury	28c. Injun	4X Minursing	Home 5 Res 28d. Describe	dence 6 Othe		v)
	s effer dea bi Director ad in by the	Certification:	3 Suicide 6 Could not b 4 Homicide determined	e co- Diseaset laine. At hom	e, farm, str	eet, factory, office		28f. Location (City or To	Street and Number wn, State)	or Rura	l Route Number,
:	ne nospi in 24 hour he Funeri pletely fille	edicai	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example 1	nysicien: To the best of my knowle niner: On the basis of examination and manner stated.	edge, death n and/or in	n occurred at the tin vestigation, in my o	ne, date and pla pinion, death oc	ice, and due to the curred at the time,	cause(s) and mandate and place, a	nner as st and due to	ated. the cause(s)
Ì	Tot	Σ	29b. Signature and title of certifier			29c. License			29d. Date signed		
0			30. Name and address of person who		3a) (Type.)54547		0ct 31	, 20	05
	'		William Crite	eutes, m.D. 73	350 1	Van Dus e n	Dr, S	Suite 35	0, Lau:	rel,	MD
	Sta Registr		31. Date liled (Month, Day, Year)	32. Registrar's Signatur	A SA	made					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35505 Certificate of Death سياً Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death C Ventura Anne рМ October | 31 2005 1:45 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Baltimore

9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 1 M 2 F New York 83 215-14-4333 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Timonium Md. 10e. Street and Number 10g. Citizen of What Country? 2525 Pot Spring Road St Stephen's Green Unit 305 21093 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ≥ 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert E. Condon Ina Driscoll 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. Patrick J. Ventura/Son 6825 Crofton Colony Ct. Crofton, Md. 21114-3276 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 ☑ Other (Specify) Entomb Dulaney Valley Mem. Grd. 11/4/05 Timonium, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or comprications that cause when death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Intracerebral hemorrhage Days Due to (or as a consequence of): Hupertension years D to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical **Examiner** Examine

burial-transit

been signed by the attending physicien and should be detached for use as the burial-tran

page 2 :

certificate

within 24 hours efter death.

To the Funeral Director: After this certific completely filled in by the funeral director.

Attending

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To the Hospital

Physician/Medical

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Completed

Be

Certification

Medical

certificate be executed

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Division of Vital Records,

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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in then "natural, or items 23a or 28a-1 shov The Medical Examination was be notified at

is marked other then

Pages 1 and 2 should be filed Maryland

Baltimore,

Health and Mental

permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other trau

sacuantities list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No

9 Unknown

24a. Was an

autopsy performed? Yes 2 No 1 Yes 26. Place of Death Check only one

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

27. Manner of Death

2 Accident

3 Suicide

29a Certifier

4 Homicide

1 Natural

5 Pending investigation

6 Could not be determined

Hospital:

30. Name and a ress of person who completed cause of death (Item 23a) (Type, Print)

1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of

2 ER/Outpatient 3 DOA 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specity) 28d. Describe how injury occurred

Injury

1 TYes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 2 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

6701 N. Charles St. Swife 4217, Towson, MD

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

Rein E. Thomas

Remi Thomas, MD

MD

D60630

11/1/05

31. Date filed (Month, Day, Year) State Registrar





John Webb UNK 05-7355 AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#20b-c.perFH.G849.11/22/05 TT

				epartment of Health and N Certificate of Death	ental Hygie! Reg.		5506
	5 A.		1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	. ⊮Physici Medic/		JOHN LISTER WEL	3B JR.	November		3:40 A M
	Examir	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
		٠ -	University Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last bird	Baltimore hday) If Under 1 Year If Under 24 Hrs.	9 Date of Birth	N/A	
-181	Funeral Director		214-64-5923 DM 20F 46	rrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye)	ar) 9.59 MAY	e (State or Foreign QVLAW
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location		10d.	Inside City Limits
	f sho	ō	MARINAIN ALLA	BAITIM	ORE CI		18 Yes 2 No
	the note	rec	10e. Street and Number	10f. Zip Code		Citizen of What Country	?
	h with	ai D	2107 HOLLINS STREE	7 2123	29	U.SA.	
	or itama	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Black, White, etc.	
36	hours after death with the Maryland tural, or Itama 23a or 28a-f show at Examinar must be notified at	by Fu	1 🛣 Never Married 2 ☐ Married 1 🕱 Yes 2 ☐ No If Yes, Give	1 ☐ Yes 2 ☒ No Specify:		Specify:	
5-0036	72 hours "natural",	ed b	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a.	Decedent's Usual Occupation	166	. Kind of Business/Indust	7CK
15	n "nai	Completed	(Specify only highest grade completed)	(Give kind of work done during most of work life. DO NOT use retired)	ang	. Aind of Business/Indus	ıry
2121	d within giene. er then "	Eo	Elementary/Secondary (0-12) College (1-4or 5+)	UNEMPLOYED 18. Mother's Nam		NIA	
	be file tal Hy d othe	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Maid	den Sumame)	
Maryland	2 should be filed within and Mental Hygiene. Is marked other than sumatic avant, the Ma	10	JOHN L. WEBB 3	SR, ERN	ESTINE	= 10	GAN
Jar	2 sh and is m			Mailing Address (Street and Number or Run	0		,
-	s 1 and 7 f Heelth item 27 other tr		LRNESTINE THOMAS 40 20a. Method of Disposition 20b. Place of	Disposition (Name of	Date 200	HORE, MD. Location - City or Town,	2/215
Baltimore	00		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	y, crematory or other place)	1/05 C	rownsville,	MD
3alti	permit. Page Depertment o Important: If any injury or once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility B	ROWNJR	FUNERAL	HOME
	00240		iehien W. Williams	2140 N. FULT		BALTO, MD.	00.0177
			23a. Part1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line. Immediate Cause (Final	lot enter the mode of dying, such as cardiac	or respiratory arrest,"	Int	proximate terval Between aset and Death
	Physician /Medical		disease or condition resulting in death)	sharp torce in	juries		
	Examiner		Due to (or as a consequence of	of):			
		Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of the control of the c	of):			
K	cuted	Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events c				
ő,	e exe	EX	resulting in death) Last Due to (or as a consequence of	of):			
8760,	cate be executed physicien and the burial-transit	dicai	d				
9 ×		/Me	IF FEMALE: 23c. If yes, outcome of pregnancy				
Вох	w requires that the death certiff been signed by the attending should be detached for use as	Physician/Me	in the past 12 months?	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Da	y Year
P.O.	t the c by the achec	hysi	1 Yes 2 No 9 Unknown 9 Unknown				
	requires thet the een signed by the rould be detache	by P	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the c	ause of death?
ord	equire	ted			1 ☐ Yes	2 No 3 Probably	y 4 □Unknown
ec G	g 2 C/	Completed			24a. Was an autopsy	24b. Were autopsy prior to comple	findings available
<u>=</u>	Th ate pag	S			performed	? death?	
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital: .gs	Othor	h (Check only one)		
ot	Phys r this ral dir	5	1 Zunpatient 2 ER/Ou		ome 5 Residence	6 ☐Other (Specify)	
Division of Vital Records,	Attanding I or death. ector: After by the funer	tlon	1 Natural 5 Pending (Month, Day Year) Ir	ime o 28c. Injury at hijury Mork?	Subject	4105 3DD	had and
Visi	Attar r dea ector by the	Ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fai	10	28f. Location (Street	and Number on Rural Ro	oute Number,
Ö	s affe	Certification:	4 Homicide determined building, etc. (Specify)	trep.t	City of Town, St	Dest Meet	, site
	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical	29a. Certifier (Check only only only only only only only only	, death occurred at the time, date and place,	and due to the cause	e(s) and manner as state	d.
	the hin 24 the F	Medi	and mariner stated.				
	S I I S	-	29b. Signature and title of certifier	29c. License number 0.C.M.E.	Nov	Date signed (Month, Day ember 1, 20	v. Year) 05
			J. M. Ste ta				
	1+1		30. Name and address of person who completed cause of death (Item 23a) (P. Avenila- Pollak MiD.	111 Penn Street, Balt	timore, Ma	ryland 212	01
-37	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	hade)			
1	Registi		NOV 0 3 2005 Beauty				
	2007		1911				

State of Maryland / Department of Health and Mental Hygiene [] [] 5 35507 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Yeer **Physician** 1:40 A 10 30 05 Wall Viola /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince Georges Southern MAryland Hospital Clinton 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex **Funeral** North Carolina 1 M 2 X F Yrs. 90 Director 242**-**78**-**4439 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 28a-f ehow Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiens and set it flems 23a or 28a-1 ehov ant; it flems 27 is marked other then "natural; or litems 23a or 28a-1 ehov ury or other traumatic event, the Medical Examinat must be notified at ury or other traumatic event, the Medical Examinat must be notified at ¥ Yes 2 No Oxon Hill Prince Georges MD Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20745 5504 Livingston Terr #301 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 X No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Black Specify Baltimore, Maryland 21215-0036 þ 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th. College (1-4or 5+) Private Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dixon Watkins Annie Worth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 5504 Livingston Terr. #301 Oxon Hill, MD. 20745 Clarence Robinson/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Clinton, MD. 11-07-05 Resurrection Cem. permit. Page Department of Important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MArshall's Funeral Home 21. Signature of Funeral Service Licensee 4217 9th. St. N.W. Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, drheart failure. List only one cause on jach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Spiral Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): ettending physician P.O. Box 68760 Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ cete has been signe, page 2 should be 2 No 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate has 2 2 No 2 🗆 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 2 No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No М s after death. 2 Accident the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours a To the Funeral E peili To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 65879+ of death (Item 23a) (Type, Print) 11701 LIVINGSten Rd, Sw 30. Name and address of person who cop 32. Registrar Signature 31. Date filed (Month, Day, Year) State 2005 Registrar

			1 - For State Registrar	State of Ma	aryland	d / Depa <i>Cei</i>	artment o	f Heal	th and Math		iene	05	355	08
			1. Decedent's Name (First, Middle, La.	st)			-		-	2. Date of Deat	h		3. Time	of Death
Н	Physici /Medio		James Wilson							Month October	Day r 25,	2005	9:05	AM M
	Examir		4a. Facility Name (If not institution, give				4b. City, Tow	n, or Loca	tion of Death			ounty of Death		
			1739 E. Nortl					timor						
B	Funeral Director		5. Social Security Numberunk 6. S	ex 7. Ag ∰ M 2□ F	e (In yrs. I. 73	ast birthday) Yrs.	If Under 1 Y Months Da		nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day, Mar 5,	Year) 1932	9. Birth Con	nplace (State untry)	or Foreign unk
	P.		Usual Residence of Decedent							11.02 3,				
	ehow		10a. State 10b. County		,	, Town or Lo							10d. Inside (•
	Ba-f	Director	MD			Baltin							1X Ye	s 2 □ No
	∯ o 2	Dire	10e. Street and Number				10f. Zip Co	de		1	0g. Citizer	of What Cor	untry?	
	e 23e	rai	1739 E. North Av					2121				USA		
	ltam Itam	n n	11. Marital Status unk	12. Was Decedent Armed Forces?	. 1	unk 13.	Vas Decedent f Yes, specify (of Hispani Cuban, Me	ic Origin? (Spe exic <mark>an, Puert</mark> o i	ecify Yes or No- Rican, etc.)	14.	Race - Amer Black, White		
36	l', or	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ ! If Yes, Give Year or Dates:	40		I□Yes 2√∑	No Spe	ecify:		Sp	pecify: b1	ack	
ŏ	2 hou		15. Decedent's Ed	ducation		16a. Deced	lent's Usual O	cupation		unk	16b. Kind	of Business/I	ndustry	unk
215	nin 7.	Completed	(Specify only highest gra	de completed) College (1-4or 5		(Give life. l	kind of work at DO NOT use re	one during stired)	most of workii	ng			,	GIII
2	d with	ĕ		ınk	,+)									
9	al Hy other	Be	17. Father's Name (First, Middle, Last)				un]	18. N	Mother's Name	(First, Middle, M	Maiden Su	mame)		unk
yla	should be filed within 72 hours after death with the Maryland and Mental Hyglene. In marked other then "natural", or itame 23e or 28e-f ehow unastic event, I'm Medical Exemples in milled at	2												
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hyglene. Importants if Item 27 is marked other then "natural", or Itame 23a or 28a-1 ehow enty injury or other treumatic event, the Medical Exercited must be callified at once.		19a. Informant's Name/Relationship (Baltimore City F	*	t	19b. Mailin	g Address (St	reet and No	umber or Rura	l Route Number,	City or To	own, State, Z	ip Code)	unk
ē,	Hea Hea tem		20a. Method of Disposition				sition (Name o		D	ate	20c. Locat	tion - City or T	fown, State	·
Baltimore,	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☑ Other (Specif			эт өгөгү, сгөп	natory or other	piace)						
≣	Departm Departm Importar eny injui		21. Signature of Funeral Service Licer	III/State		22	. Name and A	dress of F	acility					
m	Departiment of the permit of t		Ronald S.	Made, Dir	ector	St	ate An	atomy	Board	655 W.	Balt	imore	Street	
	39		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death	. Do not ent	er the mode of	dying, suc	th as cardiac o	r respiratory arre	est,		Approxima	ite
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	/Medical		resulting in death)	a. Due to (or as	a consequ	ience of):	1 com	Jun	J. J.	Suser	7		gear	0
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	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as										
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387	The law requires that the death certificate be executed tte has been signed by the attending physicien and tage 2 should be detached for use as the burial-transit	dical	•	d			·							
×	eath certific attending p for use as	Physician/Me	IF FEMALE:	23c. If yes, outcome	of pregnar	ncv					004	D-1(-1-0)		
Вох	atter of for u	clar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3	Ectopic pregna				230	. Date of deline Month	Day	Year
o.	that the de ed by the a detached t	iysi	1 Yes 2 No 9 Unknown	9☐ Unknown			(0,000)	/						
ر. م	s that ned b		Part II. Other significant conditions of	ontributing to death b	ut not resu	Iting in the ur	derlying cause	given in P	Part I.	23e. Did tob	acco u <i>s</i> e	contribute to	the cause of	death?
Records,	w requires that been signed I should be det	Completed by	Left moon	loke m	ass					1X Ye	s 2 🗆 N	io 3 🗆 Pro	bably 4	Unknown
00	s bee	ojet								24a. Was ar		4b. Were aut	opsy findings	available
	The law te has	mo lmo								autopsy	ido?	prior to or death?	ompletion of	cause of
Viital		0	25. Was case referred to medical					26. F	Place of Death	(Check only one	No	1 🗆 Yes	2 No	
>	Physician: The lithis certificate har all director, page	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 _ Inpatie	nt 2 E	ER/Outpatien	t 3□ DOA	04		ne 5 Reside		Other (Speci	ifv)	
0	ng Pl		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time of	28c. l	njury at Work?		28d. Describe ho				
Sio	death. ctor: A the fu	catie	2 Accident investigation	1				1 🗌 Yes	2 🗆 No					
Division of	or Att	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	ury - At hor c. <i>(Specify</i>	me, farm, stre	et, factory, off	ice	2	28f. Location (Str City or Town	eet and N State)	umber or Rur	al Route Nur	nber,
_	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filted in by the funeral director,		29a. Certifier 1 Certifying Ph	ysicien: To the best	of my knov	vledge, death	occurred at th	e time, dat	te and place, a	and due to the ca	use(s) and	d manner as	stated.	
	he H in 24 he Fe	Medicai	one)	niner: On the basis of and manner sta	texaminati	ion and/or inv	estigation, in n	ny opinion,	, death occurre	ed at the time, da	ite and pla	ice, and due t	to the cause(s)
	To T	Σ	29b. Signature and title of certifier	0			29c. Lic	ense numi	ber	29	d. Date s	igned (Month,	Day, Year)	
			Chisty Ch	MO			0-	181	5-1	6	oct.	27,	200	
			30. Name and address of person who	completed cause of d	eath (Item	23a) (Type,	Print)	II.	409	BALTIMO		11)	210	
	Sta	to	CHI-SHIANG (HE 31. Date filed (Month, Day, Year)	32. Registra	ar's Signat	ure 2	14411 14	408		SHLT IMO	RE!	71) 0	4202	
- 2	Registr		NOV 0 3 20	05 2000	, Di	иге	Carlot Control							

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

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3 2005 32 Registrar's Signature

			1 - For State Registrar	State of Ma	aryland		artment of Hotilicate of L		d Mental Hyg	piene 05	35510
,	Physici /Medio Examir	cal	Decedent's Name (First, Middle R OSE Aa. Fecility Name (If not institution,	Mary, give street and number),	1.00	4.1	With 4b. City, Town, or		2. Date of Dea Month Novemb	Day 1 20 4c. County of E	<u> </u>
	Funeral Director		384-34-2635	10pKins f 6.Sex 7.Ag 1□M 2XF 68		tal ast birthday) Yrs.	Balti If Under 1 Year Months Days	More If Under 24 Hours	Hrs. 8. Date of Birth fin. January 1	N/A 9,1937 Mi	Birthplece (State or Foreign County) CN19dN
	he Maryland 18e-f show	ector		ntre		Town or Lo	е				10d. Inside City Limits 1 ☐ Yes 2√√ No
	23e or 2	Funeral Director	10e. Street and Number 655 Devonshire Drive	e			10f. Zip Code 16803		1	10g. Citizen of Wha USA	t Country?
2-0036	s within 72 hours after death with the Maryland liene. I then "natural", or Itams 23e or 28e-1 show It he Medical Exacilian ment be multifud at	by	11. Marital Status 1 □ Never Married 2 □ Marri XX Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 24 If Yes, Give Year or Dates:	Ever in U.S No	1	Vas Decedent of His f Yes, specify Cubar I ☐ Yes aXXNo	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No- uerto Rican, etc.)	Black, V	American Indian, White, etc. White
-61717	ed within 72 h rgiene. ar than "natu i, the Medical	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	College (1-4or 5	5+)	(Give life. L	lent's Usual Occupa kind of work done di DO NOT use retired) VISON	urina most of	working	16b. Kind of Busine University	
yland	should be file nd Mental Hy I marked oth umatic avant	To Be	17. Father's Name (First, Middle, I Stanley Golas					Hele	Name (First, Middle, 1 2n Ignatowski		
, Mar	and 2 sh salth and n 27 la m er traum		19a. Informant's Name/Relationsh Howard S Witham		ion				Rural Route Number 1 Texas 7501		te, Zip Code)
more	wit. Pages 1 and 2 should ortment of Health and Mer ortent: If Itam 27 la marke injury or other traumatic		20a. Method of Disposition XXBurial 2 □ Cremation 4 □ Donation 5 □ Other (Sc		Ce	metery, cren	sition (Name of natory or other place ty Mem Park	" 11/		20c. Location - City State Collec	or Town, State ge, Pennsylvania
Baitim	permit. Pages Department of Importent: If i any injury or once.		21, Signature of Funeral Service L	Men Keno	rkis	1	4	6500 Yor	k Road Balti	more, Maryl	ral Home Inc. and 21212
	Physician /Medical		23a. Part1. Enter the diseas or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	complications that caused only one cuse on each ling. a	oral.	her	er the mode of dying	, such as card	diac or respiratory arr	est,	Approximate Interval Between Onset and Death
9	Examiner	er	Esquentially list conditions, if any, leading to immediate	. Cerek	1	hem	norrhagi	P			30 minutes
/ 'na	ate be executed hysician and the burial-transit	ai Examiner	Equentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequ	ı'	0	2 10 O 2 V			30 days
19/89	ate hys	Medicai	IF FEMALE:	d. <u>Pleta</u>	Stati	C bro	east Co	anCer			bycars
O. BOX	the death certific by the attending p ached for use as I	hysician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 7 No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
cords, r	w requires that the death been signed by the atte should be detached for	by P	Part II. Other significant condition	ns contributing to death b	ut not resul	lting in the ur	nderlying cause give	n in Part I.		./	e to the cause of death? Probably 4 Unknown
Ĭ	The lay ate has page 2	Completed							24a. Was a autops perform	24b. Were prior death	
or vital	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatie	ent 2 🗆 E	R/Outpatien	t 3□ DOA Other	r: 4 🗆 Nursin	Death <i>Check on on</i> g Home 5 🗆 Reside		Specify)
DIVISION	To the Hospital or Attanding Phys within 24 hours alter death. To the Funeral Director: After this o completely filled in by the funeral directs	ertification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investig	ation	ry y Year)	28b. Time of Injury	28c. Injury Work' M 1 🗆 Y	at ? es 2 □ No	28d. Describe ho	ow injury occurred	
	ital or Att irs after d ral Diract led in by	Certifi	3 Suicide 6 Could n 4 Homicide determi		ury - At hor c. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (St City or Town	reet and Number of n, State)	r Rural Route Number,
	ha Hosp in 24 hou ha Funa pletely fil	edical	29a. Certifier 1 Certifying (Check only one)	g Physician: To the best of Examiner: On the basis of and manner sta	i examinati	vledge, death on and/or inv	occurred at the time estigation, in my opi	e, date and pla inion, death o	ace, and due to the ca ccurred at the time, d	ause(s) and manne ate and place, and	r as stated. due to the cause(s)
	To t To t	M	29b. Signature and title of certifier / Winex U	Hylelhok	. , /	MD		5-000		9d. Date signed (M	105
	13		30. Name and address of person was Tamer Ab	who completed cause of d	eath (Item	23a) (Type, I	offe Stre	eet,	Baltimo	re, MD	21287
:_	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	ar's Signati	ure					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Florence Wood Tottle 2005 12:50P^M November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Blakehurst Life Care Community Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
November 23,1910 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 XF Months 216-46-2524 94 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "naturel", or iteme 23a or 28a-f show traumaild event, the Medical Examinar must be notified at Maryland Baltimore Towson 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1055 W. Joppa Rd. 21204 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: þ Specify: 3 X Widowed 4 □ Divorced Year or Dates: white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry De filed with.
I Hygiene. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be fi h and Mental H 7 le marked otl John W. Tottle Helen Doll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health ar
Important: If item 27 le
any injury or other trau Walter A. Frey III/son 32836 9612 Camberley Cir. Orlando, FL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Crematory Nov. 2, 2005 Baltimore, Maryland 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Rd. Baltimore, MD 21212 21. Signature of Funeral Service Licenses U. D. Muchel Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, pack, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dec to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 4☐Pregnant at time of death 5 Other (specify) Records, P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 TYes 2200 3 Probably 4 □Unknown Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (S. A. S. Stad Living Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury s after dea. 5 Pending 1 TYes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filled it Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Zi Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number redelle Iglehard III mo 11/01/2005 Name and address of person of o completed cause of death (Item 23a) (Type, Print) 6301 N CHALLES ST BALTIMORE MD 21212 GHACT II MD 31. Date liled (Month, Day, Year) 2. Registrar's Signature State 3 2005 Registrar NOV 0

			For State Registrar	State of Ma	aryland / l	Department of Certificate of		Mental Hygie		35512
			Decedent's Name (First, Middle	, Last)				Reg. 2. Date of Death		3. Time of Death
	Physici /Medic		JOCK	Leslie	4	ung		October, 3	Day Year 31, 2005	8:35 P M
>	Examin		4a. Facility lame (If not institution	give street and number)		b. City, Town	, or Location of De	ath	4c. County of Dea	th
			8435 Geneva				dena		Anne Ar	
	Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. last bii	thday) If Under 1 Ye Yrs. Months Da		in. (Month, Day, Ye	ear) Co	thplace (State or Foreign puntry)
	Director		218 03 5071 Usual Residence of Decedent		85			3-14-19	20 Mar	yland
	yland yland		10a. State 10b. County		10c. City, Tow	n or Location				10d. Inside City Limits
	Marie I	ctor	MD Anne	Arunde1	Pasade	ena				1 ☐ Yes 2 No
	or 28	Directo	10e. Street and Number			10f. Zip Cod			. Citizen of What Co	ountry?
	ath w		8435 Geneva				21122		U.S.A.	
	er de	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	1040	13. Was Decedent of If Yes, specify C	of Hispanic Origin? uban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whit	
36	within 72 hours after death with the Maryland ene. Than "naturel", or iteme 23e or 28e-f ehow the Madical Examiner must be collified at	by F	1 ☐ Never Married 2 ☐ Marri 3 🛣 Widowed 4 ☐ Divorced	ed 1 Yes 2 1 If Yes, Give Year or Dates:	1945	1 ☐ Yes 2) €	No Specify:		Specify: W	hite
ŏ	2 hou	bed	15. Decedent	's Education	16a	Decedent's Usual Oc	cupation	161	b. Kind of Business	
215	hin 7.	pie	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1-4or 5	5+)	(Give kind of work do life. DO NOT use re	ne during most of v ired)	vorking		•
2	filed wil Hygien other the	Completed	12			Operating			Constru	ction
<u>n</u>	tal H d oth	Be	17. Father's Name (First, Middle, I	•				lame (First, Middle, Mai		
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mendal Hygiene. I marked all Hygiene is a marked at hygiene is a marked at hygiene elements or 28e-1 ehow elements event. It is Medical Examination must be notified at	ဥ	LEO LEST 19a. Informant's Name/Relationsl	ie Young	401	Mailian Addans (On		ah Mae St		
Σ Σ	id 2 sl		Jack Young, J			07 Dalmen		Rural Route Number, C Cary, NC	27513	zip Code)
ē,	s 1 end i Health item 27 other ti		20a. Method of Disposition			f Disposition (Name of ry, crematory or other)	-	1	c. Location - City or	Town, State
Ë	Pages nent of int: If it iry or o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (St	3 □Removal from State pecify)	i i	iew Crema	1	-1-05 Ba	ltimore	, MD
Baltimore,	permit. Pages 1 end 2 should be Department of Headilb and Menia Important: If Item 27 is marked eny Injury or other treumatic a <u>pnce</u> .		21. Signature of Funeral Service I	icensee			- 1	J Gonce F		
<u> </u>	88 = 8		The file	Ec-		169 Ri	viera D	r. Pasade	ena, MD	21122
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause onleach li	d the death. Do ne.	not enter the mode of	tying, such as card	iac or respiratory arrest,		Approximate Interval Between
ا چ	Physician		Immediate Cause (Final disease or condition	-a VVIeta	astatic	Cancer o	Junkno	un primai	14/	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence				8	
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence	of):		*		
	uted J ansit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		,	- ,-				
o,	exec en and rial-tra	Еха	resulting in death) Last	Due to (or as	a consequence	of).				
68760,	ificate be executed g physicien and as the burial-transit	edicai		d						
39	= O 6		IF FEMALE:							
Вох	leath certi ettending I for use a	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death				23d. Date of del	ivery Day Year
	res that the de signed by the e be detached f	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	t time of death	5 ☐ Other (specify,				Say Tou.
۳.	that t	y Ph	Part II. Other significant conditio	ns contributing to death b	ut not resulting i	n the underlying cause	given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
Vital Records,	7 00	d by						1 ☐ Yes	2 No 3 □ Pr	obably 4 Unknown
000	aw requ is been 2 should	Completed						24a. Was an	24b. Were au	itopsy findings available
Ž.	The lav	mo						autopsy performed	d? death?	completion of cause of 2☐ No
ıta	sicien: Th certificate rector, peg	Bec	25. Was case referred to medical examiner?				26. Place of D	eath Check only one		
<u> </u>	Physic this co	ဥ	1 ☐ Yes 2 🔀 No			ilpatient 3 DOA		Home 5 Residence		cify)
ב	ding F h. After funera	io	27. Manner of Death 1 ⊠ Natural 5 □ Pending			Time of 28c. Ir		28d. Describe how i	injury occurred	
Division of	I or Attendi efter death I Director: A d in by the fu	ficat	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n	ot be 390 Place of Init	ury - At home fa	rm, street, factory, office	☐ Yes 2 ☐ No	28f. Location (Stree	t and Number or Ri	m I Poute Number
2	al or A efter I Direc d in by	Certification:	4 Homicide determine	building, et	c. (Specify)	ann, street, ractory, one		City or Town, S	itate)	nar riodia iddilibar,
	To the Hospital or Attending Physicien: within 24 hours eller death: To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier Certifyin	Physicien: To the best	of my knowledge	e, death occurred at the	time, date and pla	ce, and due to the caus	e(s) and manner as	stated.
	the H nin 24 the F nplete	Medical	Olive)	xeminer: On the basis of and manner sta	ated.			curred at the time, date	and place, and due	to the cause(s)
	To the within To the comple	2	29b. Signature and little of certifier	- Madie 1	Das	29c. Lice	ense number	29d.	Date signed (Monta	h, Day, Year)
	x1 -		Lumin.	Trucap	VUCT	01 1145	148	No	ember, -	1 2005
16)'//		38 Name and address of person of the DO OSULA	who completed cause of d	leath (Item 23a)	OU, RUSUL	ena. Ma	culand 2	21122	
	Sta	te	31. Date filed (Month, Day, Year)		ar's Signature	- U 1 0 0 0 0	1 10	- 10		
	Registr	ar	NOV A	3 2005		STEARS !		-		

Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death	Day Ye	3. Time of Death
/Medic		Edward Albat			T		10/19/20		6:00 a M
Examin	er	4a. Facility Name (If not institution, give s Chesapeake Woods			Cambr.	Location of Death		4c. County of D	nester
Funeral		5. Social Security Number 6. Sex		(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign Country)
Director		090-12-2638	M 2 F	87 Yrs.	Months Days	Hours Min.	(Month, Day, Y	918	New York
		Usual Residence of Decedent 10a. State 10b. County		10- Cit. T 1					
show	_			10c. City, Town or Lo					10d. Inside City Limits
Hygiene. ither than "natural", or Itams 23a or 28a-1 show ant, Ita Medical Examiner must be motified at	Funeral Director	Maryland Dorchest 10e. Street and Number	er	Cam	bridge		100	Chinan of Min	
a or	2	7 Algonquin Rd.				1 613	100	g. Citizen of Wha US	*
TIS 23	era		12. Was Decedent Ev	ver in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		ecity Yes or No-		American Indian,
or Ita		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No		_		Rican, etc.)		Vhite, etc.
East	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	WW II	1□Yes 2⊡No	Specify:		Specify:	White
natu	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Dece (Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of work	ing 16	6b. Kind of Busin	ess/Industry
than	m	Elementary/Secondary (0-12)	College (1-4or 5+)))		0.	7
Hygie ther ant,		17. Father's Name (First, Middle, Last)	6	E	xecutive	18. Mother's Name	e (First, Middle, Ma	Oi uiden Sumame)	
and Mental Hygiene. Is markad other than eumatic avent, I.a.M.	To Be	Julius Albat				Bert	ha Fink		
and wenter trybers or 1988 or 28s-f show treums 29s or 28s-f show treumstic svent, the Medical Examinations to cuiting at		19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mailir	ng Address (Street a	and Number or Rura	al Route Number, (City or Town, Sta	te, Zip Code)
Health a		Christine E. Albat	:/Spouse	7 Als	onquin R	d., Cambr	ide, MD	21613	
5 = 2		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	omough from State	20b. Place of Dispo cemetery, crei	sition (Name of matory or other place	e) [Date 20	c. Location - City	or Town, State
ent: I		'4 □Donation 5 □Other (Specify)	BINOVAL HOLLI STATE	MidShore	Cremation	Center 1	0/20/2005	5 Cambri	dee. MO
Importent of small file in the		signature of Funeral Service License	e L	22	Name and Addres				
0 = o a	1	Vegen forres-	James	vell	2272 Hudse	on Rd., C	ambridge.	$\frac{1}{10}$	13 1464,
		23a. Shart1. Enter(the disease, or complishock, or heart-failure. List only of	e cause on each line	he death. Do not ent	er the mode of dying	g, such as cafdiac (or respiratory afres	t,	Approximate Interval Between Onset and Death
ysician Nedical		Immediate Cause (Final disease or condition resulting in death)	Long	astive he	ar faila	(re)			months
aminer			Due to for aska	consequence of):	dionusor	acthen			wars
	e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):	J. J.				VEW CS
ransit	Examiner	that initiated events	Atken	osclenoss					cars
		resulting in death) Last	Due to (or as a	consequence of):					1
the bi	dica								
attending p	Physician/Medical	IF FEMALE:	On If was outcome of	20000000					
for us	cian	in the past 12 months?	3c. If yes, outcome of 1□Live birth 2 4□Pregnant at tir	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
ed by the detached	ıysid	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	ine or death 3					
	by PI	Part II. Other significant conditions con	tributing to death but	not resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contribu	te to the cause of death?
been sig should b	pa	Colonic canci	nome				1 ☐ Yes	2 □ No 3 €	Probably 4 Unknow
has bee	Completed						24a. Was an	24b. Wer	e autopsy findings available to completion of cause of
page	EO						autopsy performe		h?
# o	Be	25. Was case referred to medical examiner?				26. Place of Death	(Check only one)	•	
this all di	ို	1 □ Yes 2 No		2 ER/Outpatier		4 Nursing Ho	me 5 ☐ Resideni	ce 6 □Other (Specify)
After th	io io	27. Manner of Death Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	Year) 28b. Time of Injury	Work		28d. Describe how	injury occurred	
÷ 9	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e Place of Injur	/ - At home, farm, str		es 2 □No	29f Location (Stro	at and Number o	r Rural Route Number,
Director: I in by the	ertif	4 Homicide determined	building, etc.		eet, lactory, office		City or Town,		i nurai noute Namber,
To the Funeral Direct		29a. Certifier 1X Certifying Phys	ician: To the best of	my knowledge, death	occurred at the tim	e, date and place,	and due to the cau	se(s) and manne	r as stated.
na Fu oletely	edical	(Check only 2 Medical Examination)	er: On the basis of e and manner state	xamination and/or in	vestigation, in my op	inion, death occurr	ed at the time, date	e and place, and	due to the cause(s)
To the	ž	29b. Signature and title of certifier	200		29c. License		and Colonia	1. Date signed (M	fonth, Day, Year)
		////	1100/	M)	1	725935	5	101	8.05 ¹ 0/19/
				th (Item 23a) (Type,			1		

		-	For State Registrar	State of	of Mary	land / Dep <i>Ce</i>	artment of F	lealth and Death		giene	05	35514
Ī	Physicia	an	1. Decedent's Name (First, Middle, Hazel Anderso						2. Date of Dea		Year 05	3. Time of Death 10:40 A M
	/Medic Examin		4a. Facility Name (If not institution, Woodside Nurs				4b. City, Town, o	r Location of Dea	th		nty of Death	
	Funeral Director		5. Social Security Number 578–46–6793	5. Sex 1 ☐ M 2 🖾 F		yrs. last birthday, 9 Yrs.	Months Days	If Under 24 Hrs Hours Min		y, Year)	Cou	place (State or Foreign intry) ington, D.C.
	aryland show		Usual Residence of Decedent 10a. State 10b. County		100	c. City, Town or L						10d. Inside City Limits 1 Yes 2 No
	he Ma	Director	D • C •			Washing	10f. Zip Code			10g. Citizen	of What Cou	
	with 1	וֹם	6101 16th. St.	N.W.			20011			•	ISA	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or flems 23s or 28a-f show raumatic event, It a Madical Exertiner raist be in tillied at	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 W Widowed 4 Divorced	12, Was Dec Armed F	orces? 2 ∑No ive	in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	tispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.)	E	Race - Amer Black, White scify: Bla	, etc.
2-0	72 ho	Completed	15. Decedent' (Specify only highest	s Education grade completed)	16a. Dece (Give	edent's Usual Occup e kind of work done DO NOT use retire	pation during most of we	orking	16b. Kind of	Business/li	ndustry
121	withIn ane. than	ршо	Elementary/Secondary (0-12)		(1-4or 5+) Yrs.		edical Te	-		Howar	d Uni	versity
Q	Hygie other	Be Co	17. Father's Name (First, Middle, L					,	ame (First, Middle,			
/lan	Wenta Wenta arked artic ev	To B	George King						Butler			
lan,	2 sho and is ma rauma		19a. Informant's Name/Relationsh Rachel Hines/N				ing Address (Street					ip Code)
e,	1 and Health em 27		20a. Method of Disposition	Tece	2	Ob. Place of Disp	4 Madriga osition (Name of	1	Date	y VA.		Town, State
more,	ages ent of ht: if it		1 🗷 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		State		matory or other pla Memorial		22-05	Suitla	and, M	D.
Baltii	permit. Pages 1 and 2 should be Department of Health and Menta important: if Item 27 is marked any injury or other traumatic ex		21. Signature of Funeral Service L				2. Name and Addre					
ľ			23a. Part I Enter the disease, or shock, or heart failure. List of	complications that	caused the							Approximate Interval Between
feat	Physician	J.	Immediate Cause (Final disease or condition		epsis							Onset and Death
	/Medical Examiner		resulting in death)	Due to	o (or as a co	onsequence of):						
	LAMITHIE!	7	Sequentially list conditions,	b. Due to	o (or as a co	onsequence of):					-	
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8760,	ficate be executed physician and s the burial-transit	dlcal		d								
O. Box 6	e death certii the attending hed for use a	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		birth 2 nant at time	Fetal death 3	□Ectopic pregnanc □ Other (specify)	у			Date of deliment	very Day Year
ds, P.	uires that th signed by Id be detacl		Part II. Other significant condition Dementia	ns contributing to	death but n	ot resulting in the	underlying cause giv	ven in Part I.		obacco use c Yes 2XINo		the cause of death?
Vital Record	The law requir te has been si age 2 should	Completed							24a. Was autop perfo		prior to c death?	topsy findings available completion of cause of
ital		Be	25. Was case referred to medical examiner?						eath (Check only o	one)		
of \	Physicien: this certific ral director,	2	1 ☐ Yes 2 🖾 No 27. Manner of Death		Inpatient of Injury	2 ER/Outpatie	all 300A		Home 5 Resident			eity)
Ou	ding l h. After funer	tlon	1 Natural 5 ☐ Pending 2 ☐ Accident investig	(Mo	nth, Day Ye		Wo	rk?]Yes 2□No	200. 0630100 1	now injury oc	Julieu	
Division	i or Attending after death. Director: After	Certification:	3 Suicide 6 Could r	ot be 28e. Plac	e of Injury ding, etc. (S		treet, factory, office		28f. Location (: City or Tox		ımber or Ru	ral Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C		xaminer: On the		amination and/or i	ath occurred at the ti nvestigation, in my					
	To the within 2 To the complet	Me	29b. Signature and title of certifier	00			29c. Licens			29d. Date sig	ned (Month	n, Day, Year)
	0		> proce	All	New	200 n	0382	62		19 Oct	ober 2	2005
R	(5)		30. Name and address of person Dr. A. Mendhi	ratta, M	D. 24	401 Resea		. #330 R	ockville	, MD.	20850	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) OCT 2 0		Registrar's	Signature	ante					

		1	For State Registrar	State o	f Mary		partment o Prtificate				e2e005	35515
	Physicia		1. Decedent's Name (First, Middle							Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Thelma Beat: 4a. Facility Name (If not institution				4h City To	vn. or Location		ctober	16, 2005 4c. County of De	
	Examin	er	St. Thomas Mor			nab. Cer	,,	attsvi			Prince G	
	Funeral Director		5. Social Security Number 577–24–8086	6. Sex 1 □ M XX F		yrs. last birthda Yrs.	y) If Under 1		der 24 Hrs. 8. I	Date of Birth Month, Day, 1	(ear) 9. B	irthplace (State or Foreign Country) erton, Ga.
	pue *		Usual Residence of Decedent 10a. State 10b. County		100	c. City, Town or	Location					10d. Inside City Limits
	Maryle f sho	jo	D.C.			Wa	shingto	a				¥☐Yes 2☐No
	r 28a-	irec	10e. Street and Number				10f. Zip Co			10	g. Citizen of What (Country?
	23a o	ai D	# 23 54th 8	St.,S.E.				200			U.S.A.	
9	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural, or items 23a or 28a-f show other traumatic event, ite Medical Examinatinatic event, ite Medical Examinational continuation.	by Funeral Director	11. Marital Status 1 Never Married	If Yes, G	orces? 2 No ive	in U.S.	3. Was Deceder If Yes, specify 1 ☐ Yes 2√		: Origin? (Specify tican, Puerto Rica cify:	Yes or No- an, etc.)	Black, Wh	nerican Indian, nite, etc. Black
5	72 ho	eted	15. Deceder	nt's Education est grade completed)	(G	cedent's Usual (done durina r	most of working	10	6b. Kind of Busines	ss/Industry
V	ithin ne.	Completed	Elementary/Secondary (0-12)		(1-4or 5+)		DO NOT use	•	z Dont		U.S. Gov	ernment
V	filed w Hygie other ti		12th 17. Father's Name (First, Middle	Last)		CTET	icai/ii		other's Name (Fi	irst, Middle, M		CEIERCISC
yland	d be i	To Be	Mitchell 1						Lade Har	rper		
	2 should be and Mental Is marked or raumatic ev	F	19a. Informant's Name/Relation	ship (Type, Print)		19b. M	ailing Address (5	treet and Nu	ımber or Rural Ro	oute Number,	City or Town, State	, Zip Code)
Ma	alth a		Raynard Atcher	son/Son					E., Was			0019
ore G	of He of He fiterr		20a. Method of Disposition ★□ Burial 2 □ Cremation	3 □Removal from	ľ	20b. Place of Di cemetery, o	sposition (Name trematory or other	of er place)	Date	2	0c. Location - City	or Town, State
Ě	Pag ment tant: I		`4 ☐ Donation 5 ☐ Other (Specify)		incoln	Mem. Ce		10/20/		uitland,	Md.
Saltimor	permit. Pages i Department of H Important: If ite any injury or ot		21. Signature of Funeral Service	W.	X ATT		H.S.Wa	shingt	acility & So.	ns Co.	Inc.	D G 20010
	40200		23a Part1 Enter the disease of	or complications that	caused the	death. Do not	enter the mode	irrougt of dying, such	h as cardiac or re	spiratory arre	<u>asnington</u> st,	Approximate Interval Between
	return to to a		shock, or heart failure. Lis	t only one cause on	each line.		Heart D					Onset and Death
	Physician / /Medical		disease or condition resulting in death)	a		onsequence of):	near c b	Lacase				
	Examiner		Conventially list conditions	b								
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a co	onsequence of):						
	icate be executed physician and s the burial-transit	Examin	that initiated events resulting in death) Last	c	o (or as a co	onsequence of):						
8760,	be ex ician burial	aiE			(,,						
289		edicai		d								
P.O. Box	the death certific the attending poor	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		birth 2 [gnant at tim	Fetal death	3 ☐ Ectopic prec				23d. Date of o Month	delivery Day Year
	Attanding Physician: The law requires that lhe de r death. experies this certificate has been signed by the a setter. After this certificate has been signed by the ay the funeral director, page 2 should be detached to	b	Part II. Other significant condi-							23e. Did tob		e to the cause of death? Probably 4 □Unknown
CO	aw require s been si 2 should b	Completed	Coronary Arte	ry Diseas	е					24a. Was an	prior :	autopsy findings available to completion of cause of
Re	ding Physician: The lav h. After this certificate has funeral director, page 2	mo								perform	ed? death	1?
ta	ian: artifica ctor, p	Be C	25. Was case referred to medic examiner?	f					Place of Death (C			
<u> </u>	hysic this ce al dire	0	1 ☐ Yes 2 ☑ No			2 ER/Outpa		-			nce 6 Other (S	(pecify)
o u	ling P	ion	27, Manner of Death 1 ■ Natural 5 □ Pend	ling (Mo	e of Injury onth, Day Y	ear) 28b. Tim Inju	ry M	v. Injury at Work? 1 ☐ Yes		i. Describe no	w injury occurred	
Division of Vital Records,	or Attend fter death director: J	Certification:	3 Suicide 6 □ Coul	mined 200, Fla	ce of Injury Iding, etc. (- At home, farm Specify)	, street, factory,			. Location (Str City or Town		Rural Route Number,
	To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	edicai Ce	29a. Certifier 1 Certify (Check only one)	ring Physician: To t	he best of n basis of ex	amination and/	eath occurred at or investigation, i	the time, dat n my opinion,	te and place, and , death occurred	d due to the ca at the time, da	use(s) and manner ate and place, and c	r as stated. due to the cause(s)
	o the ithin 2 o the omple	Med	29b. Signature and title of certification			-		License num			d. Date signed (Mo	onth, Day, Year)
	F 3 F 8		Messis	y Pah		Smil		000	58776	0	ctober 19	,2005
K	(2)		30. Name and address of personal Doris V. P.					St. N	.E. # 21	3,Wash	ington,D.	C. 20017
	S	tate	31. Date filed (Month, Day, Yea	ar) 342	Registrar's	Signature		20 /21	,, - ,	,		
	Regis		OCT 2 0	2005	we	N A	rede					
DI	-IMH 17 Rev 1/	2001	·	0		- /						

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05 Amend Item #1 Per FHY G849 11/03/04 Retificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Delores C. Bailey October **Physician** 11:30 Am 17 , 2005 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) Examiner Burnie 9. Birthplace (State or Foreign Country) Health louriner If Under 1 Year | If Under 24 Hrs. | 8. Dale of Birth | Hours | Min. | (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthdey) **Funeral** 1□M 20%F Months 20142-1306 Usuel Residence of Decedent Yrs. October 2, 1931 Director virginia 10d. Inside City Limits 10c. City, Town or Location permit. Pagas 1 and 2 should be filed within 72 hours after deeth with the Marylen Departmant of Heelth end Mantal Hygiene. Important: if Item 27 is marked other than "naturel", or Items 23a or 28e-f show eny injury or other traumatic event, the Medical Examinat must be notified at 10a. State 10b. Count 1 ☐ Yes 2 No Director Hone Arunde 10f. Zip Code 10g. Citizen of What Country? ISA never Funeral Was Decedent Ever in U,S. Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Status Black, White, etc. Never Married 2 Married 1 ☐ Yes 2 XNo Specify: altimore, Maryland 21215-0020 Specify: Black δ 3 Widowed 4 Divorced Completed Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired)

| The contract of working life. DO NOT use retired | The contract of working life. DO NOT use retired | The contract of working life. DO NOT use retired | The contract of working life. DO NOT use retired | The contract of working life. DO NOT use retired | The contract of working life. DO NOT use retired | The contract of working life. DO NOT use retired | The contract of working life. DO NOT use retired | The contract of working life. DO NOT use retired | The contract of working life. DO NOT use retired | The contract of working life. DO NOT use retired | The contract of working life. DO NOT use retired | The contract of working life. DO NOT use retired | The contract of working life. DO NOT use retired | The contract of working life. DO NOT use retired | The contract of working life. DO NOT use retired | The contract of working life. DO NOT use retired | The contract of working life. DO NOT use retired | The contract of working life. DO NOT use retired | The contract of working life. DO NOT use retired | The contract of working life. DO NOT use retired | The contract of working life. DO NOT use retired | The contract of working life. DO NOT use retired | The contract of working life. DO NOT use retired | The contract of working life. DO NOT use retired | The contract of working life. DO NOT use retired | The contract of working life. DO NOT use retired | The contract of working life. DO NOT use retired | The contract of working life. DO NOT use retired | The contract of working life. DO NOT use retired | The contract of working life. DO NOT use retired | The contract of working life. DO NOT use retired | The contract of working life. DO NOT use retired | The contract of working life. DO NOT use retired | The contract of working life. DO NOT use retired | The contract of working life. DO NOT use retired | The contract of working life. DO NOT use retired | The contract of working life. DO NOT use retired | The 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Baile 1. Green ٩ Opn 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)

Set 2

Date 20c. Location - City or Town, State 19a. Informant's Neme/Reletionship (Type, Print) Ruth Payne/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 10/28/05 Alexandria, VA Bethel Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fatility Greene Funeral Home, INC 21. Signature of Funeral Service Licensee - E Greone 814 Franklin Street-Alexandria, VA22314 Woon 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Examine ettending physicien end I for use es the buriel-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760. act Physician/Medical Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed 2 No 1 Tes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 27. Menner of Death

1 Natural

2 Accident 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred After or Attending 5 Pending investigation aftar death.

Director: After din by the fur 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide To the Hospital of within 24 hours a To the Funeral D 1 X.Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end menner steted. cai 29a. Certifier

Registrar

30. Name end address of person who completed ceuse of deeth (Item 23a) (Type, Print)

and diret

29b. Signature end title of certifier

Kh

Attending

Physrian

29c. License number

29873

29d. Date signed (Month, Day, Year)

10/17/2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiepe 05 1 - For State Registre Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 11130 AM Gilbert Lionel Brandon Oct. 19 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 314 Franklin Ave. Berlin Worcester If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 25,1925 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Months Hours July ΫÄ 578-22-6483 80 **Director** Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits works i ral', or Itams 23a or 28e-f shov Examiner must be notified at MXYes 2 □ No Directo Ocean City MD Worcester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7901 Coastal Highway 21842 USA Funerai Pages 1 and 2 should be filed within 72 hours after death tent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?

1)CXYes 2 No WWII

If Yes, Give
Year or Dates: Korea 1 Never Married 2 X Married or, Baltimore, Maryland 21215-0036 Specify White 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced "netural" I Hygiene. othar than "netura ant, the Wedical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Electronics Engineer Electronics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ethel Thompson Enzer L. Brandon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If itam 27 is any injury or other trau once. Madeline R. Brandon (wife) 7901 Coastal Highway, Ocean City, Md. 21842 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Arlington Natl. Cem. Nov.2,2005 Arlington, VA 22. Name and Address of Facility The Burbage Funeral Home e of Funeral Service Licensee 108 William St., Berlin, Md. 21811 M00284 Enderson 231 Fart1 Enter the list as Air complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failur. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 1 3 1 PROSTATE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4☐Pregnant at time of death the 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▼ No 24a. Was an 2**/**0 No certificate 1 Yes Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After this funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1. Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only onel 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10/20/05 HU053714 30. Name and dre person who completed cause of death (Item 23a) (Type, Print) C. H. 10+1 Frankly 1 302 BeRLIN legistrar's Signature 31. Date filed (Month. State

DHMH 17 Rev 1/2001

Registrar

All Copies Are Legible. d Mental Hygiene

# 05-07111	Please Type or Print in Black Indelible Ink.	Ensure
Carl Blackman	State of Maryland / Department of He	ealth and

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		1 - State Registrar		Certificate of D	eath	Reg. I	No.	00010
*		1. Decedent's Name (First, Middle, Last)			2	2. Date of Death Month	Dav Year	3. Time of Death
Physi		Carl Scott Black	nan		C	October 2	0, 2005	11:14 A M
/Med Exam		4a. Facility Name (If not institution, give str	eet and number)	4b. City, Town, or L	ocation of Death		4c. County of Death	1
		46840 Morningside	Drive	Lexington			St. Mary	
Funera	al	5. Social Security Number 6. Sex	7. Age (In yrs. last b	Months Davs	Hours Min.	B. Date of Birth (Month, Day, Ye	ar) Coi	nplace (State or Foreign untry)
Directo	or	35U-13-7622 A	^{M 2□ F} 50	Yrs.	J	Tuly 5, 1	955 Cal	ifornia
pu *		Usual Residence of Decedent 10a, State 10b, County	10c. City, Tox	wn or Location				10d. Inside City Limits
aryia •ho	5	Manual on d Ca Manual		gton Park				1 ☐ Yes X No
he M	Directo	10e. Street and Number		10f. Zip Code		10a.	Citizen of What Co	untry?
4 12 15-0030 I within 72 hours after death with the Maryland liene Than "natural", or Itams 23a or 28e-f ehow The Modical Examinar must be notified at	ă	46940 Marriagaida	Desire	20653		IIn	ited Stat	.00
eath Ps 23	Funeral	46840 Morningside I	2. Was Decedent Ever in U.S.	13. Was Decedent of Hisp	panic Origin? (Spec	rify Yes or No-	14. Race - Ame	rican Indian,
ter d	Ë	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 XNo	If Yes, specify Cuban,	Mexican, Puerto R	ican, etc.)	Black, White	e, etc.
OUSO hours after tural, or its	Š		If Yes, Give Year or Dates:	1 ☐ Yes 2 X No	Specify:		Specify: W	hite
13-0030 72 hours af "natural", or				a. Decedent's Usual Occupati	ion		. Kind of Business/	Industry
U in a man	D	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done du life. DO NOT use retired)	ring most or working	9		
C Z IZ IO- filed within 72 Hygiene. wher than "na ent, the Mexic	Completed	12	A	ircraft Procu	rement	U	S Governm	ent
	Be	17. Father's Name (First, Middle, Last)		1	18. Mother's Name	(First, Middle, Maid	den Sumame)	
lan uld be Mental rked c	10		ackman			Lauer		
ore, Maryla is 1 and 2 should of Health and Men item 27 is marks other traumatic	- 1	19a. Informant's Name/Relationship (Type	e, Print) 19	9b. Mailing Address (Street are	nd Number or Rural	Route Number, Ci	ty or Town, State, 2	Zip Code)
and 2 and 2 balth n 27 i		CLARENCE OTTO BLACK		8510 North Pa	rkview Dr	. Supri	se, AZ 85	
ges 1 and the street or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	cemel	ol Disposition (Name of tery, crematory or other place,) Da	ate 200	. Location - City or	Town, State
Pages nent of nnt: if it		4 □ Donation 5 □ Other (Specify)	Brius	field-Echols	Cre 10/26	/2005 C	harlotte	Hall, MD.
Baltimore, permit. Pages 1 a Department of Hes Important: if item eny injury or othe	ä	21. Signature of Funeral Service Licenses	tote Juin	22. Name and Address	of Facility Bri	nsfield	Funeral H	lome P.A.
m aaes	8	Kyle S. Simons	M01206	22955 Holl				20650 Approximate
Physicia /Medic Examin	al er	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	e Cardiocusa	2	iseas	10-	Inierval Between Onset and Death
68760, ficate be executed physician and is the burial-transit	cal Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequence	ee ol):				
Box 6 ath certiff ath certiff or use as	lan/Me		ic. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown				23d. Date of de Month	livery Day Year
p.O. I that the de led by the a detached t	9	Part II. Other significant conditions cont	ributing to death but not resulting	g in the underlying cause give	n in Part I.	23e. Did tobac	co use contribute to	the cause of death?
dS, signe	1 2	î				1⊠Yes	2 □ No 3 □ P	robably 4 Unknown
i Records, The law requires t ate has been signe	0					24a. Was an autopsy performer	d? death?	utopsy findings available completion of cause of
/ita cien: ertific ctor.	B	25. Was case referred to medical		100	26. Place of Death			
of Vita Physicien: r this certific	F	2 13X Yes 2 No	ospital: 1 Inpatient 2 ER/		4 Nursing non		e 6 Other (Spe	cify) Scene
ng P Mter t	į	27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	o. Time of 28c. Injury Work	?	28d. Describe how	injury occurred	
Division of Vital of or Attending Physicien: T efter death. Director: After this certificat d in by the funeral director, pg	. action the contraction .	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home,		'es 2 □ No 2	28f. Location (Stree	et and Number or R	ural Route Number,
Dir A Direction by	1	4 Homicide determined	building, etc. (Specify)	,		City or Town, S	State)	
Division of Vital Re To the Hospital or Attending Physicien: The I within 24 hours effer death. To the Euneral Director, After this certificate he completely filled in by the tuneral director, page	Clear	29a. Certifier 1 Certifying Phys	ician: To the best of my knowled ter: On the basis of examination and manner stated.					
	Mo	29b. Signature and little of certifier	M	29c. License OCMI			Date signed (Mon	
A D		30. Name and address of person who con	mpleted cause of death (Item 23	a) (Type, Print) 111 Pe	enn Stree		more, Mar	yland 21201

State Registrar

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			1 - For State Regis	strar			Otato (ate of			iontai i iy	Reg. N	_) (,
	Physici	an	1. Deceder	nt's Name	(First, Middle	, Last)		-							2. Date of Do	eath D	av	Year	3. Time of Deat	h
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}	Examir	er		·	not institution			•			4b. (City, Town, o	or Location	n of Death		4	c. County	of Death		
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н	Funeral Director						M 25	/. Age	96		Mon			Min.	(Month, D	ay, Year		Coun		эign
			Usual Res	30-77 idence of				1							Apr. 2	5, 1	909	New	York	
	yland		10a. State		10b. County				10c. City	, Town or	Location							1	0d. Inside City Lin	nits
	a Ma	ctor	Mary.	land	Mont	gom	ery			Kens	ingto	on							1 □ Yes 2 □	No
	iff th	Dire	10e. Street								10f	Zip Code				-	itizen of W			
	ath w	rai			el Lan							2089					ted S			
	er de itams	une	11. Marital		d 00 Mass		2. Was De Armed F	orces?		S. 1	3. Was D If Yes,	ecedent of I specify Cub	Hispanic C an, Mexic	origin? (Spe an, Puerto	ecify Yes or No Rican, etc.)	0-		- Americ c, White,	an Indian, etc.	
36	irs aft	by F	_		d 2 Marr	ied	1 ☐ Yes If Yes, G Year or	ive X	0		1 □ Ye	s 2 No	Specif	y:			Specify:	whi	te	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. wher then "natural", or items 23s or 28s-f show ont, the Madical Examiner must be molified at	Completed by Funeral Director	Λ		15. Decedent		ation					Jsual Occu				16b. l	Kind of Bu			
2	hin 7	pie	Element		fy only highes dary (0-12)	st grade	Completed College		r)	life	DO NO	f work done T use retire	during mo d)	ost of worki	ng					
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. important: if item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 🗀 🖰 🖰	urial 2	Cremation	3 □Re	moval from	State	1			(Name of or other pla	!	10/2	1/05		lney,		WII, Oldio	
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Box	reatili nding usa a		IF FEMAL 23b. Was		pregnant	23	c. If yes, o										23d. Date	of delive	rv	
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Division of	i or Attending after death. Director: After I in by the funer	fical	2 □ Ad		investig	not be	28e. Plac	e of Iniu	v - At ho	me, farm.			103 2		28f. Location (Street a	nd Numbe	r or Rurai	Route Number,	
<u>S</u>	after after Dire	Certification:	4 🗆 H	omicide	determ	inea	build	ding, etc.	(Specify)	31.001, 12.	ctory, office			City or To				Trouto Truttibor,	
	spita hours meral		29a. Certif		1 Certifyin	g Physi	cian: To th	e best o	my knov	viedge, de	ath occur	red at the ti	me, date a	and place, a	and due to the	cause(s	and man	ner as sta	ated.	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific complately filled in by the funeral director.	Medical	(Chec one)	ck only	2 ∐ Miedical I	Examin	er: On the I	basis of nner stat	examinati	ion and/or	investiga	tion, in my o	opinion, de	ath occurre	ed at the time,	date an	d place, ar	nd due to	the cause(s)	
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			31 Doin 4	led (Month	Day, Year)	1	(6)	AL T	's Signat	121	MO	NIKE	<u> </u>	KY)	100	KV	100	· MI)	20802	
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BASCH, HELEN

State of Maryland / Department of Health and Mental Hygiene 05 35520 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** Ethel Louise Bond 2:13 P M 2005 13 October /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 9 Chestnut Street, Apt 415 Montgomery Gaithersburg If Under 1 Year | If Under 24 Hrs. 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🖾 F 235-38-6379 76 Yrs 31, 1928 West Virginia Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If team 27 is marked othar than "natural", or items 27s and injury or other trainments. 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County Maryland Montgomery Gaithersburg 1 ☐ Yes 2 X No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 Chestnut Street, 20877 United States Apt 415 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2 TNo 1 Never Married 2 Married 1 ☐ Yes 2 x No Specify: Specify: White þ 3 XWidowed 4 □Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 Cashier Food Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elsie Wetzel Guv S. Barnett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Faith Court, Damascus, Maryland 20872 William G. Kenney/ injury of other October 17, Kearneysville, 20b. Place of Disposition (Name of 20a. Method of Disposition Pleasant View Memorial Gardens 1 ☑ Burial 2 ☐ Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other 2005 West Virginia 22. Name and Address of Facility 21. Signature of Funeral Se DeVol Funeral Home M00689 10 East Deer Park Drive, Gaithersburg, MD 20877 Approximate Interval Between Onset and Death 23a. Part 1. Entertrie dise, se, or complications that caused the heath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or new failure. List only one cause on each line. Immediate Chuse (Final **Physician** Months Renal Carcinoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or any) Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4∏Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 2**X** No 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 1 ☐ Yes 2 🔼 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 XNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funeral Direct 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier October 14, 2005 D44791 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barry Nahin, M.D., 20528 Boland Farm Road, #104, Germantown, Maryland 20876 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2005 OCT 2 0 Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			1 - For State of Ma	ryland / Depa			Mental Hy	giene ()	5 (35521
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ı	Funeral Director		218-50-1111 1X M 2□F	(In yrs. last birthday) 59 Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da Aug 17	in 19, <i>Year)</i> 1946	9. Birthp Coun Mary	place (State or Foreign htry) 1and
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	n 72 hours after death with the Maryland "natural", or Itams 23a or 28a-f show colcal Examiret must be notified at	ai D	128 Kidwell Ave.		21617			USA		
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Baltimore,	그 든 뿐 분 .		21. Signature of Funeral Service Licensee			ess of Facility d Helfent				
m	Depa Impo any I		Hear (Flux	PO	Box160	d Helfent Greensbor	ein Fun o, MD 2	eral Hor 1639	ne, P	A
П			23a. Part1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line	he death. Do not ent	er the mode of dyi	ng, such as cardiad	or respiratory a	rrest,		Approximate Interval Between
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_	spita nours naral / fillec		29a. Certifier Certifying Physician: To the best of	my knowledge, deatl	occurred at the ti	me, date and place	and due to the	cause(s) and ma	inner as sta	ated.
	To the Hospital within 24 hours a To the Funeral C completely filled i	edicai	(Check only 2 Medical Examiner: On the basis of	examination and/or in	vestigation, in my o	pinion, death occu	rred at the time,	date and place,	and due to	the cause(s)
	To the company	Σ	29b. Signature and title of certifier	- 1	29c. Licens	se number		29d. Date signe	(Month, E	Day, Year)
)			Valene gwarker	/V	HC	0518	21	10/2	6/0	5
			29b. Signature and title of certifier Value Warmer 30. Name and address of person who completed cause of de VALERIE GOODMAN 31. Date filed (Month, Day, Year) 32. Registrar 33. Registrar	ath (Item 23a) (Type,	eville R	L, Cent	reville	, mo	216	17
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar	's Signature				•		
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CHARLES

State of Maryland / Department of Health and Mental Hygie \mathfrak{D} e0.51 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 4.35PM Rosalie V. ctoser /Medical 4a. Facility Name (If not institution, give street and number) 4b. Çity, Town, or Location of Death 4c. County of Death Examiner HREMS Haure Home De Grace tar torc If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 8/6/1913 5. Social Security Number **Funeral** 6. Sex Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 28 □ F Mary Yand Yrs. 212-03-5947 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examinar must be notified at Director MD Harford Aberdeen 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3452 Churchville Road 21001 U.S.A. or Items 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 23☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No þ 3
☑ Widowed 4 □ Divorced natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than ** Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 0 In home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Latka Valerie Osheka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Yates (Daughter) 970 Whisler Rd. Etters, PA 17319 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Harford Mem. Gdns. 4 ☐ Donation 5 ☐ Other (Specify) 11/2/05 Aberdeen, Maryland 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 21. Signature of Funeral Service Licenses any i 29a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final Pnysician erelmo Vascular 8 hrs disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Lines Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Tetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 99 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 10 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After fo the Hospital or Attending 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ∩ 24 hou₁~ the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mann 32600 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kammelm MULLIAM HDC RWO! evolutions+ Harre De 32 Registrar's Signature Pay Oeas State Registrar

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	Physici /Medic		1. Decedent's Name (First, Middle, Last) India Latoya	Bright		2. Date of Death	Day Year
	Examir Funeral Director		4a. Facility Name (If not institution, give street a	General Hoz	day) If Under 1 Year If Under 24	Death	4c. County of Death HOWOWA 9. Birthplace (State or Foreign Country)
	pu *		Usual Residence of Decedent 10a. State 10b. County	100 City Town		10 11-20	
	Maryla f sho	ō	MD Howard	10c. City, Town	Woodbine		10d. Inside City Limits 1 A Yes 2 □ No
	or 28a	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?
	ath wil	ralD	1975 Daisy Road		21797		U.S.A.
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "naturel", or Items 23a or 28a-f show may injury an other treumetic event. The Medical Evant must be prufited at once.	by Funeral	1 Never Married 2 Married 1 If Y	s Decedent Ever in U.S. ed Forces? Yes 2 ANo as, Give or Dates:	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P 1 ☐ Yes 2 No Specify:	? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
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re,	item 2		20a. Method of Disposition	20b. Place of D	isposition (Name of crematory or other place)		. Location - City or Town, State
Baltimore,	Page ment of the man o		1 ☐ Burial 2 ②Cremation 3 ☐ Remova `4 ☐ Donation 5 ☐ Other (Specify)	from State Metro	Fnrl Svcs 1		lexandria, VA
Ball	permit Depart Import any in	<	21 Signarifie of Funeral Service Licensee	worder	22. Name and Address of Facility 246 N. Washin	Snowden Fu gton St Ro	neral Home, P.A. ockville,MD20850
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.O. Box 6	The law requires that the death certificate be executed te has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months?	s, outcome of pregnancy Live birth 2 Fetel death Pregnant at time of death Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
<u> </u>	res that the igned by be detac	y Ph	Part II. Other significant conditions contributin	g to death but not resulting in th	ne underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
Spuc	v requires been sign should be	ted by				1 ☐ Yes	2 ☑ No 3 ☐ Probably 4 ☐ Unknown
al Kecords,		Completed				24a. Was an autopsy performed?	
VIII V	ysicien: Th is certificate director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	1 PInpatient 2 □ ER/Outpa	Out	Death Check only one)	- Flow 10 - 11
on of	th. Th. After this of funeral directions	-		Date of Injury (Month, Day Year) 28b. Tim Inju	e of 28c. Injury at	g Home 5 Residence 28d. Describe how in	
DIVISION	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, farm building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	dical	one) 2[] Medical Examiner: On	manner stated.	eath occurred at the time, date and pl r investigation, in my opinion, death o	ccurred at the time, date a	nd place, and due to the cause(s)
	withi To the	Σ	29b. Signature and title of certifier	4.1	29c. License number	29d. D	Date signed (Month, Day, Year)
		-	Margorwate	on mis	1041548		0-11-05
	71.5184.CT		29b. Signature and title of certifier May AWA 30. Name and address of person who completed MAR 60T WATSON 31. Date filed (Month, Day, Year) OCT 1 9 2005	cause of death (Item 23a) (Ty	- Paturent Pki	wy Colu	n bia No Z1044
**	Sta Registra	te ar	31. Date filed (Month, Day, Year) OCT 1 9 2005	32 Registrar's Signature	barle		

State of Maryland / Department of Health and Mental Hygiene [] 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Thelma Ries Bushby 11:55 P M October 2005 17 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Casey House-6001 Muncaster Mill Rd. Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last binhday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2 🔀 F 214-20-8576 89 Director Aug. 25 1916 Maryland Usual Residence of Decedent the Maryland 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f ehov the Medical Examiner must be politied at Md. Montgomery Rockville Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 4000 Montpelier Road 20853 permit. Pages 1 and 2 should be filed within 72 hours after death v Dependment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a env injury or other treumatic event, the Medical Examinant must. United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 No White Š 3 ⊠ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Ries, Jr. Alverta Lucas Α. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James D. Bushby / Son 4004 Wild Grape Court, Rockville, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 10/19/05 Metropolitan Crem. 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Va. 21. Signature of Funeral Service Licensee 22 Name and Address of Earling Funeral Home murie P. O. Box 5038, Laytonsville, Md. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician END STAGE PARKINSON'S DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit and Due to (or as a consequence of) P.O. Box 68760 physicien IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Month Dav Year 5 Other (specify) cate hes been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 ACUTE RENAL FAILURE Completed 2° DaNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy lindings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 ☐ Yes 2 No funeral director. Be 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No 2 this 2 ER/Outpatient 3□ DOA HOSPICE 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 4 hours after death, -uneral Director: Aft elv filled in by the fur investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral D Hospital Certifying Physician: To the heet of my knowledge death occurred at the time, date and place, and due to the eause(s) and inamier as stated. Medicai 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) ů. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 18/05 30. Name and address of person who sempleted cause of death (Item 23a) (Type, Print) CHARLES HARRISON, M.D. 6001 MUNCASTER MILL ROAD, ROCKVILLE, MD. 31. Date liled (Month, Day, Year) 327 Registrar's Signature State Registrar 19 2005

			1 - For State Registrar	State of Marylar	nd / Dep <i>Ce</i>	artme rtifica	nt of He te of D	ealth and Death		giene 0 0 5	35526
	Physic	an	Decedent's Name (First, Middle, Last)						2. Date of Dea Month	th Day Year	3. Time of Death
	/Medi		Milton	B1azek						17, 2005	9:11 P M
	Exami	ner	4a. Facility Name (If not institution, give	·				Location of Dea	ith	4c. County of Dear	h
		4	Holy Cross Nursin 5. Social Security Number 6. Se		1		er 1 Year	Ville If Under 24 Hr		Montgome	
	Funeral Director			7. Age (In yrs. 78	Yrs.	Month		Hours Mir	Month, Day April	9. Bin 29, 1927 Ne	hplace (State or Foreign ountry) W York
	Maryland	tor	Maryland Montgon		ty, Town or Lo		ing				10d. Inside City Limits 1 ☐ Yes 2 X No
	th with the 23a or 28	al Dire	10e. Street and Number 9221 Whitney Stre	et			ip Code 20901		1	0g. Citizen of What Co	untry?
900	in 72 hours after death with the Maryland I "natural", or Itema 23s or 28s-1 show patical Experiment be notified at	d by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 45-4			edent of His ecify Cuban 212 No		Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
Maryland 21215-0036	d within 72 h piene. r than "natu	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give life.	kind of v DO NOT		ion iring most of wo	orking	16b. Kind of Business/	Industry
21	77 50			+4	Soci	lal W	orker			State of M	aryland
yland	0 9	To Be	17. Father's Name (First, Middle, Last) Martin Blazek					Mary	me (First, Middle, I Blazicek		
	permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked any injury or other traumatic woods.		19a. Informant's Name/Relationship (Ty Helga Blazek – Wi		19b. Mailir 9221	ng Addre Whit	ss (Street ar Eney S	nd Number or A treet;	Rural Route Number Silver Sp	City or Town, State, 20	ip Code) 901
Baltimore,	Se la		20a. Method of Disposition 1 ☐ Burial 2 🏗 Cremation 3 ☐ F	lemoval from State	Place of Dispo	matory or	other place,			20c. Location - City or	
Ē	Pag ment tant:		4 Donation 5 Other (Specify)	For						Brentwood	
Ball	Depar Depar Impor any in		21. Signature of Funeral Service Licens: Myeluni.	"Klobert						ldi Funera Silver Spri	1 Home ng MD 20904
8760,	Physician // Medical Examiner but/sicien and physicien and physicien and step for the physician street but/sicien and physicien street but/sicien	dical Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence).	uance of):	c Ca	ncer				Interval Between Onset and Death
P.O. Box 6	death certif e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3 □	Ectopic Other (s	pregnancy pecify)			23d. Date of defi Month	very Day Year
	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions con	tributing to death but not res	ulting in the ur	nderlying	cause given	in Part I.		pacco use contribute to	the cause of death?
of Vital Records,	The ate h page	Completed							24a. Was an autops perform	y prior to c ned? death?	opsy findings available ompletion of cause of
/ita	ertific actor.	Be	25. Was case referred to medical examiner?						ath Check only on	9)	
<u></u>	hysi this c	ည	1 105 225 110	ospital: 1 Inpatient 2 I				4 LES INUISING I	dome 5□ Reside	nce 6 Other (Spec	ify)
Z	ling F After funer	on:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury a Work?		28d. Describe ho	w injury occurred	
Division	or Attending Physicien: after death. Director: After this certific in by the funeral director.	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stre	M eet, facto		s 2 No	28f. Location (Sti City or Town	reet and Number or Rui , State)	ral Route Number,
_	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Medical Ce	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir	sician: To the best of my kno ter: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred estigatio	at the time	date and place	e, and due to the ca arred at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
	o the	Me	29b. Signature and title of certifier	and mainler stateu.			c. License r			d. Date signed (Month	
)	5+1		Dan A	Resal	1 pm		D522			10/18/200	
			30. Name and address of person who co Alan R. Seagal M.D	mpleted cause of death (fter 1500 Fore	23a) (Type, I st Gle	Print) n Rd	; Silv	er Spri	ing MD 20	910	
	Sta Registr	_	31. Date filed (Month, Day, Year)	32 Registrar's Signa	ture	uls					

					artment of Health and N	lental Hygie	2005 35527
			1. Decedent's Name (First, Middle, Last)	Per FH G852 2/10	7/06 THI Death	Reg.	
	Physic		_	DATTEV			Day Year 10:45PM
	/Medi Examir		CHARLOTTE R 4a. Facility Name (If not institution, give street and	BAILEY	4b. City, Town, or Location of Death	OC LODEI	4c. County of Death
	LAGITIII	ICI	Fairland Nursing		Silver Spring	г .	Montgoemry
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.		
	Director		578-26-9420 1DM XD	F 87 Yrs.	Months Days Hours Min.	8. Date of Birth Sept 25,	1918 New Jersev
	pu »		Usual Residence of Decedent 10a, State 10b, County	10a City T			
	sho	5		10c. City, Town or Lo	lver Spring		10d. Inside City Limits
	the M	ect	MD Montgomery 10e. Street and Number 531 Randol		T		1. ☑ Yes 2 ☐ No
	72 hours after death with the Maryland natural', or Itama 23a or 28a-1 show dical Executiver cust be notified at	Funeral Director	+3312 Octagon Lar	oh Road, 119B	10f. Zip Code 20904	10g.	Citizen of What Country? U.S.A.
	ier death Itama 2	nera	11. Marital Status 12. Was I	Decedent Ever in U.S. 13. V	Vas Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
9	after or Ita		1 ☐ Never Married 2 ☐ Married 1 ☐ Y	es 2 🖸 No		Rican, etc.)	Black, White, etc.
8	72 hours natural', ilcal Era	d by		, Give 1 or Dates:	Yes 2 No Specify:		Specify: Black
5	"natu	ete	15. Decedent's Education (Specify only highest grade complet	ed) 16a. Deced	ent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 16b	. Kind of Business/Industry
21215-0036	be filed within 72 h ital Hygiene. id other than "natu event, I. e Medical	Completed	Elementary/Secondary (0-12) College 12th		ekeeper		U.S. Capitol
d 2	e filed Il Hygie other vent, II	e Co	17. Father's Name (First, Middle, Last)			e (First, Middle, Maid	
Maryland	should be id Mental marked o matic eve	To B	Tom Byrd			lena For	
ary	shou ind M mar umat	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and Number or Rura	al Route Number, Ci	ity or Town, State, Zip Code)
ž	alth a alth a 27 is		Juanita Braxton-Da		2 Octagon Ln S:		
ore,	S T S T S T S T S T S T S T S T S T S T		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal fr	20b. Place of Dispos cemetery, crem	sition (Name of patery or other place)		. Location - City or Town, State
Ĕ	Pag ment ant: I		'4 □ Donation 5 □ Other (Specify)			•	Adelphi, MD
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or the traumatic evone.		21. Signature of Funeral Service Doensed	22.	Name and Address of Facility ST	owden F	uneral Home,P.A. ckville,MD20850
	70 = 8 Q		Cary TXHOC				
			23a. Part1. Enter the disease, or complications the shock, or hear failure. List only one cause of	at caused the death. Do not ente on each line.	or the mode of dying, such as cardiac of	or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		resulting in death)	TASTATIC BRE	AST CANCER		6Months
	Examiner		Due	to (or as a consequence of):			
		ıer	Se uential list conditions bb.	to (or as a consequence of):			
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events				
Ó	e exercien ar		resulting in death) Last Due	to (or as a consequence of):			
68760,	cate be executed physicien and the burial-transit	dicai	d				
		Mec	IF FEMALE:				
Вох	death certific e attending p id for use as	lan/	in the past 12 months?		Ectopic pregnancy		23d. Date of delivery Month Day Year
o.	0 0 0	Physician/Me	1 Vac 2 12 140 4 4 Pr	egnant at time of death 5 🗌 nknown	Other (specify)		January Tour
<u>α</u>	res that the igned by th be detache		Part II. Other significant conditions contributing t	o death but not resulting in the unc	derlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?
Records,	requires een sign hould be	ed by				1 🗆 Yes	2 No 3 Probably 4 Munknown
000	> 00	olete				24a. Was an	24b. Were autopsy findings available
æ	9 7 9	Completed				autopsy performed	prior to completion of cause of death?
	i ician: T h certificate rector, pag	Be C	25. Was case referred to medical		26. Place of Death	(Check only one)	No 1 ☐ Yes 2 No
of V	si si d	ToE	examiner? 1 Test 2 No Hospital: 1	☐ Inpatient 2 ☐ ER/Outpatient	Oth		6 ☐Other (Specify)
				tte of Injury 28b. Time of Injury Injury		8d. Describe how in	
sio	Attending r death. ector: After by the fune	cati	2 Accident investigation		M 1 ☐ Yes 2 ☐ No		
5	or Al after o Direc in by	Certification:	determined 286. Pl	ace of Injury - At home, farm, stree ilding, etc. <i>(Specify)</i>	et, factory, office	8f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	Hospital		29a. Certifier 1/2 Certifying Physician: To	the best of my knowledge, death	occurred at the time, date and place, a	nd due to the cause	(c) and manner an etotod
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edicai	(Check only 2 Medical Examiner: On the one)	e basis of examination and/or inversancer stated.	occurred at the time, date and place, a sstigation, in my opinion, death occurred	d at the time, date a	and place, and due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License number	29d. [Date signed (Month, Day, Year)
}	10		July -		D28656	C	october 17, 2005
	0		30. Name and address of person who completed c				20070
				Second Ave # Registrar's Signature	404B Silver Sp	ring, MD	20910
	Sta Registr			Hegistrar's Signature	W		

State of Maryland / Department of Health and Mental Hygiene [] [] 5 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 810PM **Physician** AR 2005 OCTOBER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Somerford Place Annapolis Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | 08/04/1917 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2 🖔 F Director 225-20-4229 88 Virginia Usual Residence of Decedent Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show the Madical Examiner must be notified at Directo 1 X Yes 2 No Maryland | Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2717 Riva Road 21401 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Teacher Education it of Health and Mental Hyg If Item 27 Is marked other or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should Edward J. Byers Mariam Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claiborne B. Beall/ Son #6 Chelsea Court Annapolis, MD 21403 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If any Injury or ance. 4 ☐ Donation 5 ☐ Other (Specify) Huntt Crematory 10/19/2005 Waldorf, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dementia Vr5 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I ary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the attending physicien and thed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery signed by the atter in the past 12 months? 3 □Ectopic pregnancy 4 Pregnant at time of death Month Year Day 5 Other (specify) o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> ANEMIA Completed 2 ☐No 3 ☐ Probably 4 ☐Unknown TEMPORAL ARTERITIS 24a. Was an Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No autopsy perform PORIPHERAL NEUROPATHY this certificete of Vital 1 Yes 2 No : After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 27. Mann of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending death. investigation 2 Accident 1 Yes 2 No within 24 hours after death
To the Funers! Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 [] Homicide To the Hospital or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 046360 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VETERAN'S HIGHWAY, SUITE 204 MILLERSINGE

DHMH 17 Rev 1/2001

State Registrar 31. Dale filed (Month, Day, Year)

Rom

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiere 15 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year William Sergeant Busik 16, /Medical October 2005 7.40 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Anne Arundel Medical Center Annapolis
If Under 1 Year | If Under 24
Months | Days | Hours | If Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Months Yrs Director 1919 California 568-05-9141 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location ?7 is marked other than "neturel", or Items 23a or 28a-f show traumatic event, the Medical Evantrian must be notified at 10d. inside City Limits 1 ☐ Yes 2 X No Directo Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5205 River Crescent Drive 21401 Funeral United States death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Importent; if item 27 is marked other than "neturel", or thereny injury or other traumait. XYes 2□No 1942-Yes, Give 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 1971 Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Executive Director USNA Alumni Assoc. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John H. Busik Lillian Sauerbrunn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia R. Busik / Spouse 5205 River Crescent Drive Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 10/17/2005 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) cancer esophaneai Priysician MOS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Error Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760, the attending physician Physiclan/Medical as the l IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown signed by Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by endocarditis 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has certificate 1 Yes 2 No To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 은 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Medical Certification: 5 Pending investigation 1 Natural within 24 hours after death. To the Funerel Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10/16/2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bestgate Rd. Annapolis, Md. Conjumo Strau 31. Date filed (Month, State Registrar

			For State Registrar		State	of Maryla		artment rtificate			and M	lental H	ygiene Reg. No.	105	355	30
	Dii		1. Decedent's Name (First,	Middle, La	ist)							2. Date of D	eath Day	Year	3. Time o	of Death
	Physici /Medi				Brown							10	13	05	1:20) A M
	Examir		4a. Facility Name (If not ins	_				1		Location of				ounty of Death		
			Heartland He							ville				ince G		
	Funeral Director		5. Social Security Number 207–20–3603		Sex 1 □ M 2120 F	7. Age (In yrs	: last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of B (Month, E 11 2	lav Year)	9. Birth Con 9 New .	place (State Intry) Jersey	or Foreign
	and		Usual Residence of Deceder 10a. State 10b. C			10c. C	ity, Town or Lo	ocation				-			10d. Inside C	City Limits
	the Marylan 28e-f show politied at	jo	D.C.			1	Vashing	ton							K □Yes	s 2 No
	the 288-	Director	10e. Street and Number					10f. Zip (Code			· · · · · ·	10g. Citize	on of What Co	untry?	
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	death ms 2:	era	11. Marital Status	Dere	12. Was Dec	edent Ever in (J.S. 13.	Was Decede	ent of His	spanic Ori	gin? (Spe	cify Yes or N		Race - Amer		
21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or Items 23a or 28e-f show the Medical Examinar nout be inclified at	by Funeral	1 □ Never Married 2 □ 3 □ Widowed 4 □ Div		Armed F 1 Yes If Yes, G Year or I	2 🔀 No ive		If Yes, speci 1 ☐ Yes 2	ify Cubar	n, Mexican Specify:	i, Puerto	Rican, etc.)		Black, White	ack.	
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21	d wit giene er the	TO.	12th.				D	omesti	ic				S	elf_Emr	loyed	
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Maryland	uld b Aenta rked tic •	To E	William Rol	inso	n					Bet	ty M	Arshal	.1			
an	sho s ma	ľ	19a. Informant's Name/Rel	ationship	Type, Print)		19b. Maili	ng Address	(Street a	nd Numbe	r or Runa	l Route Num	ber, City or	Town, State, Z	ip Code)	
Baltimore, M	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel", or Items 23a or 28e-1 show any injury or other treumatic event, the Medical Examination must be inclified at ADE8.		Amanda C		•	20b.	7627 Place of Dispo	Barlo	owe	Road,		dover,		20785 ation - City or 1	Town, State	
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8760,	cate be executed physician and the burial-transit	dicai Examiner	Sequentially list conditions if any, leading to immediate cause. Emer Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	c	(or as a conse										
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Division	f or Attending after death. Director: After in by the fune	Certification:	3 ☐ Suicide 6 ☐ 0	Could not b	e 28e. Plac	e of Injury - At I ling, etc. (Spec	nome, farm, sti ify)				-	28f. Location City or To	(Street and i	Number or Rui	ral Route Nun	nber,
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			For State Registrar	State of Waryt	Ce	rtificate of	Death		Reg. No.	J	33331
9	Physici	an	Decedent's Name (First, Middle, La	st)				Date of D Month	Day	Year	3. Time of Death
	/Medio		Lelia Mary Bush						er 27,		5:45 A M
	Examir	er	4a. Facility Name (If not institution, giv			4b. City, Town, o	or Location of Death	1	4c. Cou	nty of Death	
N. A.	(a)		Anne Arundel Medi			Annapo				Arun	
· ·	Funeral Director	8	579-12-9049	7. Age (In)	yrs. last birthday, Yrs.	Months Days		8. Date of Bi (Month, D		9. Birthi Cour Wash	place (State or Foreign ntry) ington, DC
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	ath w	rai	306 Linden Ave.	1			106			USA	
920	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Madical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 X No lit Yes, Give Year or Dates:	n 0.5.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2X No	Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or N o Rican, etc.)	1	ace - Americ lack, White, city: Whi	etc.
21215-0036	in 72 hours n "natural", fedical Exc	Completed	15. Decedent's E (Specify only highest gra	ide completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wor	kıng	16b. Kind of	Business/In	dustry
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	filed Hygid Sther	Ö	17. Father's Name (First, Middle, Last,)			18. Mother's Nan	ne (First, Middle			
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Baltimore,	permit. Pages 1 and 2 Department of Health s Important: If item 27 is any injury or other tra once.		1 ☐ Burial 2 🏋 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	y) .	Kalas Cı	matory or other pla rematory	10-2	28-05	Edgewa	ater,	MD
Ball	Depart Import any in		21. Signature of Funeral Service Line	1598			ess of Facility Gomons Isla				
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ls, P.O	ires that the de signed by the a l be detached f	Š	Part II. Other significant conditions of	contributing to death but not	resulting in the u	Inderlying cause giv	ven in Part I.				ne cause of death?
orc	w require been si should	ted						10	Yes 2 No	3 Prob	ably 4 @Unknown
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Vital	icien: Th certificate rector, pag	Be	25. Was case referred to medical	/			26. Place of Dea				
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o t	Attending Physicien: The r death. ector: Atter this certificate ha ector: Atter this certificate haby the funeral director, page		27. Manner of Death	28a. Date of Injury (Month, Day Yea	28b. Time o				how injury occ		7
Division	nding f ath. r: After e funer	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		r) Injury		Yes 2 □No				
/isi	Attendii death. octor: A by the fu	fice	3 ☐ Suicide 6 ☐ Could not b	289. Place of injury - F	Al home, farm, st	reet, factory, office		28f. Location	Street and Nur	nber or Rura	l Route Number,
á	itel or arter rel Dire	Certification:	4 Hornicide	building, etc. (Sp	ecify)			City or To	wn, State)		
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	nysician: To the best of my niner: On the basis of exam and manner stated.	knowledge, deat nination and/or in	h occurred at the til vestigation, in my o	me, date and place opinion, death occu	and due to the red at the time,	cause(s) and r date and place	manner as si e, and due to	ated. the cause(s)
	To the within	Σ	29b. Signature and title of certifier	Alkum		29c. Licens	5707 8		29d. Date sign	ned (Month, 27/2)	Day, Year)
	15		30. Name and address of person who	completed cause of death (Item 23a) (Type, Medical		as In	narok	1, M1) 21	401
Ph,	Sta Registr		31. Date filed (Mooth, Day, Year).	32 Segistrar's Si			/		, , .,		
DH	MH 17 Rev 1/2	**		JAMES SALL	No Per						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie 15 1 - For State Registral Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** рМ Elizabeth Cinotti October 18, 2005 2:40 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Laurel Prince George's If Under 1 Y If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□ M 2√X Days Months Hours Min. Yrs. Director 220-14-5562 81 April 15, 1924 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f ehow item 27 is marked other than "natural", or items 23a or 28a-f ebor other traumable event, in a Noulcal Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Prince George's <u>Beltsville</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3108 Chapel View Drive USA Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: White ð 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be f and Mental Menta Kennard Harford Helen Diddy 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 le an injury or other trai 3102 Chapel View Drive, Beltsville, ce of Disposition (Name of Date 20c. Location John Peter Cinotti/ Husband Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State October 24, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 □Donation 5 NOther (Specify) Entombment Fort Lincoln Cemetery 2005 Brentwood, Maryland 21. Signature of Funeral Service Licensee Francis Address Collins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 23a. Page. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Pneumonia /Medical Due to (or as a consequence of) Examiner Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner sician and burial-transit certificate be executed Sepsis Due to (or as a consequence of): attending physician for use as the buria Vital Records, P.O. Box 68760 Physician/Medical Osteoporosis IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Cther (specify) the detached 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4XXUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy performed? Yes 2 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2₹ No 1X Inpatient 2 ER/Outpatient 3 DOA of this is 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Division or Attending 1 X Natural 5 Pending Injury after death. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 24 hours a 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the vithin 2

State Registrar

8

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Parmjit Singh Aujla,

OCT 20

NIOGENER

House

M.D

32. Registrar's Signature

HALLES

30. Name and address of personal completed cause of death Item 23a) (Type, Print)

2005

29c. License number

d42580

5632 Annapolis Road, #13, Bladensburg, MD 20710

29d. Date signed (Month, Day, Year)

October 18, 2005

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ALFREDO CONTRERAS 35533 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2005 **Physician** Contreras Alfredo 10:13 PM OCT. 16, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE CITY SINAI HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) 7/09/1957 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Days Hours Mexico 1**X** M 2 ☐ F 245-53-0536 48 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23s or 28e-1 show any injury so other traumatic event, the Modical Examinist must be notified at any injury so other traumatic event, the Modical Examinist must be notified at any injury so. Beaumont TX Jefferson 1 ☐Yes 2X No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7420 Shady Lane 77713 Mexico Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Race - American Indian, 11. Marital Status Black, White, etc. Yes 2 1 Never Married 2 Married 1⊠Yes 2□No Specify: Mexican Mexico Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4or 5+) Concrete finisher Construction 18. Mother's Name (First, Middle, Maiden Surname)

Lupe Tinajero 17. Father's Name (First, Middle, Last) Trinidad Contreras 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2413 Letterkenny Rd. TRLR1A Chambersburg, PA. Antonio Contreras/Brother 17201 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition San Pedio Petalo Augustinos Jerecuaro G.T.O., 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 10/28/05 Mexico 4 □ Donation 5 □ Other (Specify) of Funeral Service Licensee PHILIP AD RIVALDI FUNERAL SERVICE, P. A 21. Signaturi 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) wousel to Gunshot **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to in introductions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Examiner The law requires that the death certificate be executed ete has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use confribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1. Yes 2 □ No 24a. Was an autopsy performed? After this certificete 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1X Yes 2 □ No 1 Inpatient 2 XER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending Subject after death. shet 16/05 1 ☐ Yes 2 No М investigation 20:5 2 Accident 3 Suicide 4 Homicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) unknowy 18 Pacton place, Wood lawh, within 24 hours a
To the Funeral C
completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) and manner stated To the 29d. Date signed (Month, Dey, Year) OCT. 17, 2005 29c. License number 29b. Signature and title of certifier O.C.M.E ella 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 PENN STREET, BALTIMORE, MARYLAND 21201 LABILICUAH

State Registrar 31. Date filed (Month, Day, Year) 20 32. Regisfrar's Signature

			For State Registrar		State	of Maryla	nd / Dep	artment of	Health Death	and M		gieze	5	35534
	Dhusisi	2	1. Decedent's Name (First,	, Middle, Las	st)						2. Date of Dea	ath Day	Year	3. Time of Death 10:50 M
	Physici /Medic		Betty A. (October	19, 20	05	
	Examir	ner	4a. Facility Name (If not in: Rose Manor	stitution, give	street and n	ım <i>ber)</i>		4b. City, Town,				4c. County		_
2	Firegral		5. Social Security Number	6. S	өх	7. Age (In yr	s. last birthday) If Under 1 Yea		r 24 Hrs.	8. Date of Birt	h	9. Birth	nplace (State or Foreign
	Funeral Director		220-24-3688	1	□ M 2/CXF	96	Yrs.	Months Day	s Hours	Min.	(Month, Da) 1/12/1	909		ryland
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	ar dea	nue	11. Marital Status		Armed F		U.S. 13	. Was Decedent of If Yes, specify Cu	Hispanic Oi Iban, Mexica	rigin? (Spe an, Puerto	ecify Yes or No- Rican, etc.)	- 14. Rad Bla	ce - Amer ick, White	ncan Indian, a, etc.
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21215-0036	be filed within 72 hours after death with the Maryland tall hygiene. id other than "natural", or itema 23a or 28a-f show other than "natural", or itema 12a or 28a-f show event, the Modical Examinar must be notified at	Completed		ecedent's Ec	lucation de completed)	16a. Dec	edent's Usual Occ e kind of work don	upation	st of work	ina	16b. Kind of B	usiness/l	ndustry
121	han "	mple	Elementary/Secondary ((1-4or 5+)	\lile.	DO NOT use retir	red)					
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Baltimore,	permit. Pages 1 and 2 should be Department of Health and Mental Important: if item 27 is marked any injury or other traumatic evonce.		20a. Method of Disposition	nation 3 🗆		State	cemetery, cri	osition (Name of ematory or other power) What Memor			/ / 2005	20c. Location		
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			27. Manner of Death 1 Natural 5	Pending		of Injury nth, Day Year,	28b. Time Injury	W			28d. Describe h	now injury occur	red	
Division	deal deal ctor	Certification:	2 Accident 3 Suicide 6 4 Homicide	investigation Could not b determined		se of Injury - A	t home, farm, s	M 1	Yes 2		28f. Location (S City or Tox		ber or Ru	ral Route Number,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registra Amend Item #5 PER FH G850 12/09/105 OF Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Physician October 4:30 AM Virginia Ruth Clipp Karen 2006 2 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown r 1 Year | If Under 24 Hrs. 15925 Clarence Pike Rd. Washington 216 214-84-6611 If Under 1 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🛛 F Yrs. 42 Director Aug.30,1963 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Item 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event. The Medical Examinating at the notified at 1 Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 15925 Clarence Pike Rd. 21740 USA Funerai 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status e filed within 72 hours after de al Hygiene. other than "natural", or Item Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 Tes ZXNo Baltimore, Maryland 21215-0036 Specify: þ Specify: 3 Widowed 4 Divorced White Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Housewife Home permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If Item 27 is marked of the any Injury or other traumeth 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ernest Rogers Dorton Jean Juanita Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15925 Clarence Pike Dr. Hagerstown, Maryland Richard A. Clipp - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) Cedar Lawn Mem. Park Oct.26,2005 Hagerstown, Maryland 21. Signature of Juneral Service Osborned Furner Earlin Home, P.A. 425 S. Conococheague St.Williamsport,MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 44 months Physician ato splenic disease or condition resulting in death) /Medical Due (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury Due to (or as a nonsequence of) Examiner the attending physicien and hed for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year detached for 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown δ 23e. Did tobacco use contribute to the cause of death? signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗌 Inpatient 2 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: Hospital or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated To the within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie D46473 MI alon completed cause of death (Item 23a) (Type, Print) Name and address of person T. Hagenstown. 15H-6 MD 113 32. Registrar's Signature State 2 4 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 5 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Cynthia Marie McGee Cuillier October 12, 2005 12:16 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF 57 438-74-8359 Louisiana 1948 June 16. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or Iteme 23a or 28e-f show eny injury or other traumatic event, the Macdical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1X Yes 2 No Director Maryland Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15005 Health Center Drive 20715 United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ▼ No Specify: Specify: Black à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Healthcare Executive Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Clarence McGee, Sr. Mildred Payne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7903 Old Barn Road, Bowie, MD Tonia Smith (niece) 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XX remation 3 ☐ Removal from State Chesapeake Crematory 10/21/05 Beltsville, MD * 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility McGuire Funeral Service 21. Signature of)Funeral Service Licenses Undre Mompso 7400 Georgia Ave. N.W., Washington, D.C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 10515 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in triated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 20 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: No Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 5 Pending investigation Natural 1 🗌 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of perspn who completed cause of death (Item 23a) (Type, Print) Himee Anne Trundel 2. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

9

2005

DHMH 17 Rev 1/2001

Saltimore, Maryland 21215-0036

The law requires that the death certificate be executed

or Attending Physician:

Division of Vital Records, P.O. Box 68760,

burial-tran

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Director;

within 24 hours after To the Funeral Direct

		•	For State Registrar	State o	f Marylan	id / Depa <i>Cer</i>	urtment of H tificate of i	lealth and N Death	Mental Hygi ™	₽ •0 0 5 g. No.	3	35537
			1. Decedent's Name (First, Middle,	Last)					2. Date of Death Month		/ear	3. Time of Death
	Physicia /Medic		Leonard Fi	ore (Colella				October	17, 200	5	4:30 P M
	Examin		4a. Facility Name (If not institution,		mber)			Location of Death		4c. County of		
			11726 Veirs Mi	11 Road 6. Sex	7. Age (In yrs.	(a at hirthday)	Wheato	n If Under 24 Hrs.	8. Date of Birth	Montg		Ty lace (State or Foreign
	Funeral Director		5. Social Security Number 201-03-6680	1.32M 2□F	7. Age (in yrs. 85	Yrs.	Months Days	Hours Min.	(Month, Day,	Year) 1920	Coun	ington, DC
		-	Usual Residence of Decedent		- 03				ildy 3, 1		mab.	
	yland		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation				1	0d. Inside City Limits
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2	ed will	Con		4		Elect	ronics E			epartment		Commerce
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Nai	12 sh h and 7 ia n traun		19a. Informant's Name/Relationsh Michael A. Cole						ra <i>l Route Number,</i> ensingtor			C000)
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altimore,	nit. P artme ortan injur		21. Signature of Funeral Service L			Cemete		es of Facility in	2005 <i>[]</i> s Funeral			Virginia
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Вох	ieath certifica attending plant for use as t	M/ui	IF FEMALE: 23b. Was decedent pregnant		itcome of pregn		Ectopic pregnance	1		23d. Date		
	deat	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of o		Other (specify)			Monti	h	Day Year
P.O.	that the death cert ed by the attendin detached for use	Physician/M	9 Unknown						220 Did tob	anna una cantrib	use to th	ne cause of death?
ŝ,	ires tha signed d be de	by	Part II. Other significant condition	ns contributing to d	eath but not res	suiting in the u	nderlying cause giv	en in Part I.				ably 4 Unknown
Vital Records,	w requir been si should	Completed										
3ec	e law has t ge 2 s	mpl							24a. Was an autopsy perform	/ pri	or to cor ath?	psy findings available mpletion of cause of
a			or Western design					00 Di/ D	1□ Yes 2	□X No 1 □	Yes	2□ No
₹	ysician: The is certificate hadirector, page	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DOA Ott	or	th (Check only one ome 5 🔀 Reside		(Specifi	ici
ō	ਦ = <u>''</u>	n: To	27. Manner of Death	28a. Date	of Injury	28b. Time o			28d. Describe ho			77
ion	nding lath. r: After e funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investig	9	nth, Day Year)	Injury		Yes 2 □ No				
Division of	or Attendation of Director:	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ned 28e. Plac	e of Injury - At h	nome, farm, str	eet, factory, office		28f. Location (Str. City or Town		or Rura	I Route Number,
ā	ital or A rs after ral Directed in by	Cer										
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	(Check only 2 Medical I	g Physician: To th Examiner: On the I	pasis of examin	owledge, deat ation and/or in	h occurred at the til vestigation, in my o	me, date and place pinion, death occu	, and due to the ca rred at the time, da	use(s) and mani ite and place, an	ner as si nd due to	tated. the cause(s)
	To tha twithin 24	Med	one) 29b. Signature and title of certifier		nner stated.		29c. Licens	se number	29	d. Date signed	(Month,	Day, Year)
	N N N		Alr	aralyo.	non	7 MIE		-2766		10/18/		
1	5+1		30. Name and address of person	who completed care	ise of death (Ite	m 23a) (Tvne	Print)			/ '		
	,		4	swami.	mp	11119	Rockvii	le Pike #	G100 R	ockville	2 M	D 20852
	Sta	ate	31. Date filed (Month, Day, Year)	32.	Registrar's Sign	ature	N/s	,				
	Regist	rar	OCT 19	2005	W D	· Marie						

		1 - For State Registrar		of Marylan	d / Depa	artment rtificate	of H	ealth a Death	ind M		gienje Rag. No.	005	35538
Physic		1. Decedent's Name (First, Middle, Margaret Sander		3						2. Date of De Month 10/14/		Year	3. Time of Death 10:00 P M
/Med Exami		4a. Fecility Name (If not institution,	give street and nu	mber)		4b. City, T	Town, or	Location o	f Death		4c. C	ounty of Deat	h
	•	4903 Sundown Cir				Bowi						nce Ge	
Funeral Director		544-48-4413	3. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs. 61	last birthday) Yrs.	If Under 1 Months	Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da 12/05/	1943	9. Birti Co Ore	hplace (State or Foreign untry) gon
perillinities, Intersystem A 1.2 13-0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23e or 28a-f show eny injury or other traumatic event, the Medical Evantment be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Prince 10e. Street and Number 4903 Sundown Ci 11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced 15. Decedent's (Specify only highest Elementary/Secondary (0-12) 17. Father's Name (First, Middle, L. John H. Sander 19a. Informant's Name/Relationship	12. Was Dec Armed F. 1 Yes, G. If Yes, G. Seducation grade completed) College (Bow edent Ever in U prces? 2 M No ve Dates:	16a. Dece (Give life. Profe	10f. Zip 0 207 Was Decede If Yes, specification 1 Yes 2 dent's Usual kind of work DO NOT use	ent of His fly Cubar No Occupa k done d e retired)	Specify: tion uring most 18. Mother Jean nd Numbe	r's Name Law1	(First, Middle, Cence	USA 16b. King Princ Commu Maiden S	Town, State, 2	ncan Indian, a, etc. te Industry ges ollege
Dallingte, IV permit. Pages 1 and: Department of Health Importent: If item 27 eny injury or other tr ones.		James W. Chaire 20a. Method of Disposition 1 Burial 2 Acremation 4 Donation 5 Other (Sp. 21. Signature of Funeral Service L.	3 □Removal from ecify)	State 20b. F	Place of Disponentery, cremetery, cremetery	osition (Nammatory or oti ematory or oti emator 2. Name and	e of her place y Addres	10 10 s of Facility	0/19 Robe		20c. Loca Waldo Evans	ation-City or orf, MD s Funer	
Certificate be executed with a set as the buriat-transit set as the buriat-buriat		23a. Pan1. Enter the disease, shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. First or any increase of the cause (Disease or injury that initiated events resulting in death) Last	a. Ma1 Due to b. Hep Due to	caused the deat each line. ignant l (or as a conseq atic Car (or as a conseq (or as a conseq	Hemator uence of): rotid uence of):		of dying	g, such as o	cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
death death e atten	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	utcome of pregna birth 2 Feta nant at time of d	I death 3	□Ectopic pre □ Other (spe					23	3d. Date of deli Month	very Day Year
The law requires ate has been sign page 2 should be	Completed by P	Part II. Other significant condition	s contributing to o	death but not res	ulting in the u	nderlying ca	luse give			24a. Was auto perfo 1 Yes	an osy ormed?	No 3 Pro	the cause of death? obably 4 Unknown topsy findings available completion of cause of
On Of VICAL ding Physicien: 1 n. After this certifical funeral director, p	ion; To Be	25. Was case referred to medical examiner? 1 □ Yes 2 ▼ No 27. Manner of Death 1 ▼ Natural 5 □ Pending	28a. Date (Mor		ER/Outpatier 28b. Time o Injury	f 28	Bc. Injury Work	r: 4 □ Nui at ?	rsing Hor	(Check only one 5 K Resi	dence 6	Other (Spec	cify)
To the Hospitel or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	Certification;	2 Accident investig: 3 Suicide 6 Could n 4 Homicide determin	at he	e of Injury · At hi ling, etc. (Specif	ome, farm, sti y)	M reet, factory,		′es 2 □ l	1.5	28f. Location (City or To		Number or Ru	iral Route Number,
he Hospit in 24 houn he Funera pletely fille	edicai	29a. Certifier (Check Day one) Certifying 2 Medicel E	Physicien: To the xaminer: On the land man	e best of my kno basis of examina nner stated.	wiedge, deat tion and/or in	h occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, a	and due to the ed at the time,	date and p	place, and due	to the cause(s)
To the To the comp	M	29b. Signatule and title of certifier	J. A	ne	SO2	290.	License	number	555	881	29d. Date	signed (Month	n, Day, Year)
		30. Name and address of person v David A. Morowi					N.W.	. Sui	te 2	05 Wash	ningto	on, DC	20010
S Regis	tate trar	31. Date filed (Month, Day, Year)		Registrar's Signa		neck)							

State of Maryland / Department of Health and Mental Hygiene 15 Certificate of Death Reg. No. 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** BEATRICE CATHERINE DOWDY **OCTOBER** 2005 1:15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner OUEEN ANNE'S CORSICA HILLS NURSING HOME CENTREVILLE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🖾 F 91 Director 214--01--8033 31, 1913 MD Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits rel', or iteme 23a or 28e-f shov Expressions to be notified at 1 Yes 2 No by Funeral Director QUEEN ANNE'S MD STEVENSVILLE 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code death with 204 PENNICK DRIVE USA 21666 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. o filed within 72 hours after call Hygiene. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 Yes 2 No WHITE Specify: Specify: 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) BOOKKEEPER BANKING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Importent: if Item 27 is marked oth any lioury or other treumatic event ang. Be JOHN J. BEILEIN MARY C. THIM 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES H. DOWDY, JR./SON 204 PENNICK DR., STEVENSVILLE, MD 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition DULANEY VALLEY MEMORIAL GARDENS 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 10/21/2005 TIMONIUM, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK RD., CHESTER, MD 21619 Approximate Intervat Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tranediate Cause (Final disease or condition resulting in death) **Physician** lul neum on cu /Medical Due to (or as a consequence of) Examiner Sequentially tist conditions, I any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner attending physician end for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 4 Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ should be 1 ☐ Yes 2 ☐ APo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed? 27 No 1 Yes 2 No certificate 1 ☐ Yes Division of Vital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 ☑ No PNursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٤ this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 Yes 2 No death. investigation 2 Accident Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide To the Hospitel o within 24 hours af To the Funerel D 29a. Certifier **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Mgnth, Day, Year) 10/18/0005 203 True Clashy Mos 2/4/9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D. D anop Mrs 1108 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar OCT 1 9 2005

ORIGINAL

			1 - For State Registrar	State of	Maryland	•	artmen rtificat			d Me		iene	005	35540
	- A	Z-rec	1. Decedent's Name (First, Middle, La	st)	,					2.	Date of Deat Month	h Day	Year	3. Time of Death
п	Physici /Medio		Mary Catherine	Duckett							10	23	2005	11:25 a ^M
>	Examir		4a. Facility Name (If not institution, give						Location of D			4c. (County of Death	
	- Jan 18		39762 Lady Balti						rdtown				. Mary'	
	Funeral Director		219-34-9548	ex 7 □M 2⊠F	7. Age (In yrs. Ia		Months	1 Year Days	Hours I	Min.	Date of Birth (Month, Day, –11–19)	Year)		place (State or Foreign Intry) Land
	pug *		Usual Residence of Decedent 10a, State 10b, County		10c. City	. Town or Lo	cation							10d. Inside City Limits
	Aaryla r eho	٥	300	1		1								1 ☐ Yes 2x No
	28a-	Director	MD St. Ma:	cy s	Le	onard	10f. Zip	Code			10	0g. Citiz	en of What Cou	intry?
	with 38 or	۵	39762 Lady Balti	nore Ave	ทแค		,	2065	1			IIni	ted Sta	tes
	death ma 2:	Funeral	11. Marital Status	12. Was Deced	dent Ever in U.S	S. 13.	Was Dece	dent of His	spanic Origin	? (Specif	y Yes or No-		4. Race - Amer	ican Indian,
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "natural", or Itama 23e or 28e-f ehow any injury or other traumatic event, the Medical Examinator must be invitted at once.	by Fun	1 ☐ Never Married 2 ☐ Married 3 ☐ Wildowed 4 ☐ Divorced	Armed Ford 1 Tes 2 If Yes, Give Year or Da	2 [3 [No		lf Yes, spe 1 □ Yes	-	Specify:	uerto Rio	can, etc.)		Black, White Specify: B1	ack
Maryland 21215-0036	2 hou	Completed	15. Decedent's Ed	ducation		16a. Dece	dent's Usu	al Occupa	tion	f working		16b. Kir	nd of Business/li	ndustry
215	thin 7	pie	(Specify only highest gra	College (1-	4or 5+)		_		uring most of	WOIKING				
7	od wil	Son	12			Home	emake	r					Home	·
nd	d oth	Be	17. Father's Name (First, Middle, Last,							,	First, Middle, M ilia Bu			
S	Men Merke Marke	၉	James Grantley G											
Jar	2 sh and le rr		19a. Informant's Name/Relationship (-	Town, State, Zi	
	1 and 1ealth em 27	10	Gladys M. Ducket 20a. Method of Disposition	t/Daught		39/6			Ltimor	e Av			ation - City or T	MD 20650
Baltimore,	it of h		1 ⊠ Burial 2 ☐ Cremation 3 ☐		CE	emetery, crer	matory`or o	other place	not 1				ntown,	
ij	t. Partmer		4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Strvice Licer		DL.	-								eral Home
Ba	Depa Impo		type	uner	2	3	30195	Thre	e Noto	ch Ro	oad, Ch	ar1		11, MD 2062
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that ca one cause on ea	used the death ich line.	n. Do not ent	er the mod	de of dying						Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition	. Car	dia	resp	112	100	4	OUX.	2621	-		Oriset and Death
	/Medical Examiner		resulting in death)	Due to (c	or as a consequ	uence of):		(J					
b	LXaiiiilei	L	Sequentially list conditions,	b	CAD))								**
	bed isit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (c	or as a consequ	dence of):								
	and and II-tran	Examiner	that initiated events resulting in death) Last	cDue to (c	or as a consequ	uençe of):						_		
8760,	cate be executed physician and the burial-transit	a E	l l	. 0	rdel	ethra	185							
687	licate phys s the	edical		_ d	(0,00	.,,,,,	(
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc			_					2	3d. Date of deliv	very
Вох	that the death cer ed by the attendir detached for use	Cial	in the past 12 months? 1 Yes 2 XNo	4∐Pregna	rth 2 ☐ Fetal ant at time of de		JEctopic p ∃Other (s _i						Month	Day Year
P.O.	it the d by the tached	hys	9 ☐ Unknown	9 Unkno	wn									
	res that signed b	y P	Part II. Other significant conditions of	ontributing to dea	ath but not resu	ulting in the u	nderlying (cause give	n in Part I.		23e. Did tob	oacco u	se contribute to	the cause of death?
ğ	w require been sig should b	Pd t	 								1 □ Ye	s 2[No 3□Pro	bably 4 Onknown
000	law requ as been 2 should	Completed									24a. Was a autops			opsy findings available ompletion of cause of
ž	The lav	E									perform	med?	death?	200 No
<u>ta</u>		Bec	25. Was case referred to medical						26. Place of	Death (Check only on			
>	Physician: r this certific ral director,	To	examiner? 1 Tes 2 X No	Hospitaf: 1 ☐ In	patient 2 🗍	ER/Outpatier	nt 3 D	Othe Othe	r: 4 🗌 Nursi	ng Home	5 Reside	ence 6	Other (Spec	ufy)
n 0	ng Pt fter th		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date o (Month	f fnjury n, Day Year)	28b. Time o Injury	f :	28c. Injury Work	at ?	28	d. Describe ho	ow injury	occurred	
Sio	Attending r death. ector: After by the fune	catio	Z ☐ Accident Investigatio				М		′es 2□No					
Division of Vital Records,	al or Att	Certification:	3 Suicide 6 Could not b 4 Homicide determined	200. Flace	of Injury - At ho g, etc. <i>(Specif</i> y		reet, factor	y, office		281	f. Location (St. City or Town			ral Route Number,
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edical (29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example (Check only one)	ysician: To the land mann	sis of examinat	wledge, deat tion and/or in	h occurred vestigation	at the tim	e, date and p inion, death	occurred	d due to the ca at the time, da	ause(s) ate and	and manner as place, and due	stated. to the cause(s)
	To the I within 2. To the I complet	Me	29b. Signature and title of certifier	, ,			29	c. License	number		2	9d. Date	signed (Month	, Day, Year)
	0		A .	Hah.	,)	470	66		10	-25	.05
			30. Name and address of person who	completed cause	of death (Item	23a) (Type,	Print)		-					
_			Avani D. Shah, 2	2650 Ced	ar Lan	e Cour	t L	eonai	dtown	, Mar	ryland	206	50	
	Sta Regist		31. Date filed (Month OCT 2 5	2005 32.	gistrar's Signa	W A	book	,						

State of Maryland / Department of Health and Mental Hygiepe For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 9:00a M October 18, 2005 Marie Trapani DiPietro /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Hebrew Home Rockville If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🗙 F Months 80 Dec.1, 1924 Washington DC Director 579.22.9592 Usual Residence of Decedent death with the Marylend 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County in then "naturel", or iteme 23a or 28a-f ehow the Modical Examiner count be notified at MD Bethesda 1 Tyes 2 No Montgomery Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20814-4942 U.S.A. 4959 Battery Lane Apt. 523 Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. Peges 1 and 2 should be filed within 72 hours after nent of Heelth and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2€ No Specify: f Yes, Give Year or Dates: Specify: þ 3 ☐ Widowed - W☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coltege (1-4or 5+) Secretary Accounting 12 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ie marked Sebastiana Salafia Vittorio Trapani 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges .

Department of Heelth anvironment if Item 27 ier any Injury or other tra-4515 Willard Avenue Apt. 1003 Chevy Chase, MD 20815 Pauline T. Zulli/ Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery Oct. 22, 2005 | Suitland, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 21. Signature of Funeral Service Licenses 5130 Wisconsin Avenue NW WDC 23a. Part1. Enter the insease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he at failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastake disease or condition resulting in death) Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, many leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to [or as a consequence of] Examiner The law requires that the death certificate be executed burial-transit the attending physicien and Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time ol death 5 Other (specify) Yes 22No 9 Unknown 9 ☐ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed/ 1 ☐ Yes 2 ☐ No certificate 1 Yes 2 No Physicien: in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After or Attending 5 Pending investigation 1 Matural 1 Yes 2 No death. 2 Accident after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 T Homicide pellil 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical ţ 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ပ္ 2 055258 October 18, 2005 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ratulle Wilks Mentreso B 6121

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

20

2005

32. Pegistrar's Signature

		•	For State Registrar	State of Maryland / Depa	artment of Health and M rtificate of Death	ental Hygier		35542
, a			1. Decedent's Name (First, Middle, Las	1)		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Sherman E. DeWitt			October 20	•	11:35A M
	Examir		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death	4	c. County of Death	
	3		9401 Suland Circ		Ellicott City If Under 1 Year If Under 24 Hrs.	0.0	Howard	
	Funeral		5. Social Security Number 6. Se	VM 2DE	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	ar) Coui	
	Director		212 24 0624 Usual Residence of Decedent	76 Yrs.		12/29/1928	west.	Virginia
	/iand		10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
	Man Lied	ţo	MD Howard	E1	licott City			1 ☐ Yes 🏖 No
	n the	Director	10e. Street and Number		10f. Zip Code	10g. (Citizen of What Cou	ntry?
	oth with the Marylan 23a or 28a-f show	aίΩ	9401 Suland Cir	cle	21042		USA	
	ee E	Funeral	11. Marital Status	12, Was Decedent Ever in U.S. 13.1 Armed Forces?	Was Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
98	or It		1 ☐ Never Married 2 ☑ Married	1 5 Yes 2 □ No 1946 —	1 ☐ Yes 2 ☑ No Specify:		Specify: Whi	te
8	72 hours after deeth with the Maryland "natural", or Iteme 23a or 28a-f ehow calcal Examinational be notified at	d by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed.	Year or Dates: 1960	dent's Usual Occupation	166	Kind of Business/In	
21215-0036	n 72 ho "natur	Completed	(Specify only highest grad	de completed) (Give	kind of work done during most of worki DO NOT use retired)	ng Tob.	Kind of Businessylli	dustry
12	within iene. then *	mo	Elementary/Secondary (0-12)	College (1-4or 5+) Tracto	or Trailer Driver		Grocery	
	be filed tal Hygind other event,	Be C	17. Father's Name (First, Middle, Last)			(First, Middle, Maid		
Maryland	d a d	OB	Darwin Ivan DeW	/itt	Alta Le	е		
ary	ets promi	Γ.	19a. Informant's Name/Relationship (7	* *	ng Address (Street and Number or Rura			Code)
	and 2 saith a n 27 le		Alice DeWitt/Wife	9403		icott City	y, MD 21	042
altimore,	_ + = -		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	20b. Place of Dispo	sition (Name of matory or other place)	ate 20c.	Location - City or To	own, State
Ĕ	Pag ment ant: I ury o		4 □Donation 5 □ Other (Specify	Crest Lav	vn Mem. Gards. 10/			
alt	permit. Pages 1 Department of H Important: If Ite eny Injury or ot once.		21. Signature of Funeral Service Licen:		2. Name and Address of Facility Har			
8	405 g		Herony Ku		112 Old Columbia P		ott City,	
			shock, or heart failure. List only of	plications that caused the death. Do not ent one cause on each line.	er the mode of dying, such as cardiac c	r respiratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	· pancreatic	cancer			6mo
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):				
9.		-	Sequentially list conditions,	b. Due to (or as a sonsaquenes of):				
	and I-transit	Examiner	cause. Enter Underlying Cause (Disease or injury	, , ,				
	execu n and al-tra	xai	that initiated events resulting in death) Last	C. Due to (or as a consequence of):				
8760,	death certificate be executed e attending physiclan and od for use as the burial-transit	licai		d.				
9	ifficat g phy as th	edi						
Вох	th certifica ending pl	Physician/Med	23b. was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy		23d. Date of deliv	
	death he atter ed for u	Sicia	in the past 12 months? 1 Yes 2 No		Other (specify)		Month	Day Year
P.0	at the de	Phy	9 Unknown					
	The law requires that the site has been signed by the bage 2 should be detache	þ	Part II. Other significant conditions co	ontributing to death but not resulting in the u	nderfying cause given in Part I.		o use contribute to t 2 No 3 □ Prol	pably 4 Unknown
Vital Records,	w require been si should l	Completed						
ec	e law has b je 2 si	nple				24a. Was an autopsy performed?	prior to co	opsy findings available impletion of cause of
al F		Ö				1 ☐ Yes 2 🔀 I		2 No
V.	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	26. Place of Death			
o		5	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpatient 2 ☐ ER/Outpatier 28a. Date of Injury 28b. Time o	1 3 DOA 4 Nursing Ho	me 5 Residence 28d. Describe how in		ý)
OU	iding th. : After funer	tlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury	f 28c. Injury at Work? M 1 \(\text{Yes} \) 2 \(\text{No} \)			
Division	f or Attending after death. Director: After	fica	3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, str	reet, factory, office	28f. Location (Street		al Route Number,
Ö	P 4 5 E	Certification;	4 Homicide	building, etc. (Specify)		City or Town, Sta	a(θ)	
	To the Hospitel or At within 24 hours after d To the Funeral Direct completely filled in by		29a. Certifier 1 Certifying Ph	ysician: To the best of my knowledge, deat	h occurred at the time, date and place,	and due to the cause	(s) and manner as s	stated.
	he H in 24 ihe F plete	edical	one)	niner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurr	ed at the time, date a	and place, and obe t	o the cause(s)
	With To T	Σ	29b. Signature and title of certifier	٨	29c. License number		Date signed (Month,	
	2			\sim	P 35 25 4		10/21/200	5
	DO)		0 1 100 10	completed cause of death (Item 23a) (Type,		7. 101	21220	
V	210		31. Date filed (Month, Day, Year)	1005, Caton 32. Agistrar's Signature	Que BALIMON	TE INAM	21229	
	Sta Regist	ate rar	OCT 2 1 2	EV	land.			
		-		The state of the s	ALBERT S			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** MARVEL ROSALIE DRUMMOND /Medical 4a. Facility Name (If not institution, give street and number 4b. City. Town, or Location of Death County of Death Examiner 8. Date of Birth (Month, Day, NOV 27 If Unde 5 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign 6. Sex **Funeral** 1 M 2 F Months Days Min. Hours 220 32 4355 72 NOV 1933 MARYLAND Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Itame 23a or 28a-f ahow of Health and Mental Hygiene. Item 27 is marked other than "natural", or Itame 23s or 28s-f ahov other traumatic avent, If a Medical Examir at must be notified at 1 Yes 2 No Funeral Director MARYLAND ALLEGANY FROSTBURG 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 17706 MT. SAVAGE ROAD 21532 U.S. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 XWidowed 4 ☐ Divorced WHITE Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) IVADELL BUCKALEW JOSEPH McKENZIE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 61 FROST VILLAGE, FROSTBURG, MD 21532 HELEN McATEER / AUNT 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 5 ± 5 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any injury or once. FROSTBURG MEMORIAL PARK 10/31/05 FROSTBURG, MD 22 Name and Address of Facility 21. Signature of Funeral Service Licenses 60 W. MAIN STREET SOWERS FUNERAL HOME, P.A. FROSTBURG, MD 21532 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** hetas latic unknauen disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Equantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) physicien and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Stendso 1 ☐ Yes 2 MNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Heart -AILURE 2 No 2 🗆 No 1 TYes Division of Vital : After this certification funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ٩ 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 4 hours after death. Funeral Director: Aftely filled in by the fur 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifie Medical (Check only and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) w 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 BRONDWAY CHANG MID SATURNINA ost burg 32. Pegistrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 2 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie (20) Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Day 23 Year Month October Lorraine Carter 2000 : 08 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Washington Hagerstown 18615 Maugans Avenue If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 1 ☐ M 2 💢 F 219-07-0293 Usual Residence of Decedent May 29,1922 83 Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 🛛 No Mary Land Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21742 USA 18615 Maugans Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Aircraft Manufacturer Processor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Isabelle Brinham Anna Harry Samuel Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18615 Maugans Avenue Hagerstown Maryland <u> H. Lee Dovey - Husband</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 → Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Cedar Lawn Mem. Park Oct. 27, 2005 Hagerstown, Maryland 21. Signature of Funeral S OSBOTTE AFORTELFACTION HOME, P.A. 425 S. Conococheague St.Williamsport,MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) 20 monte Colon Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 ☑No 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 1 Natural Injury 5 Pendina

/Medical Examiner The law requires that the death certificate be executed physician and s the burial-trans Box 68760, as the attending use 5 Division of Vital Records, P.O. the ģ has

Physician

/Medical

Examiner

Funeral

Director

r than "netural", or Items 23e or 28e-f show the Medical Executive right be notified at

n 27 is marked other than "n r traumatic event

permit. Pages 1 and 2. s Department of Health ar Important: If item 27 is any injury or other trau QDG2.

Pnysician

Be Completed by Funeral Director

2

Examine

Physiclan/Medical

by

Completed

Be

2

Certification:

Medical

2 Accident

4 Homicide

(Check only one)

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

this After To the Hospital or Attending death. after death within 24 hours a

State Registrar

do

investigation

determined

6 Could not be

mo

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number 0 4166

1 ☐ Yes 2 ☐ No

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

they ers town

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C(or mack 11110

31. Date filed (Month, Day, Year) 32. Registrar's Signature

OCT 2 4 2005

For

	State of Maryland / Department of Health and M	ental Hygienen n = '	35515
te gistrar	Certificate of Death	Reg. No.	70040
dent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician /Medical Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 le marked other then "netural", or items 23e or 28e-f ehow any Injury or other treumetic event. It is Modical Examination until be notified at once.

Baltimore, Maryland 21215-0036

DORINE DESHIELD

Physician /Medical Examiner

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, Certification: To

To Be Completed by Funeral Director Be Completed by Physician/Medical Examiner

State Registrar			Cert	ificate	e of D	eath			Reg. N		O		
1. Decedent's Name (First, Middle, Last)								2. Date of De Month		ay	Year	3. Time of Dea	ith
Dorine Hilda	DeShi	eld						Oct.			005	12:10A	М
4a. Facility Name (If not institution, give st	reet and number)			4b. City,	Town, or L	ocation o	of Death		4	c. County	of Death		
SALISBURY REHAB &					SBURY			804		WICC	MICO		
5. Social Security Number 6. Sex 1	and the second	e (In yrs. last birti		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Aug. 18	th y, Yea 3 1	912	Coui	place (State or Fo ntry) yland	reign
Usual Residence of Decedent		10c. City, Town		-41								Ind Incide City Li	mito
10a. State 10b. County												I0d. Inside City Li 1 XYes 2 [
Maryland Wicomi	CO	Fru	111								1111 1 0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
10e. Street and Number	_			10f. Zip							What Cour	ntry ?	
300 Dulaney Ave		Everia II C	12.16	1	826	- noin Ori	ain? (Ca	anitu Van ar Na		.S.P	A - Americ	can Indian	
TI, Warter States	 Was Decedent Armed Forces? 1 ☐ Yes 2 		IS. W	Yes, spec	ify Cuban	Mexicar	1, Puerto	ecify Yes or No Rican, etc.))-		ck, White,		
1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	10	11	□ Yes 2	2 XNo	Specify:				Specif	y: Bla	ack	
15. Decedent's Educa		16a.	Decede	ent's Usua	l Occupat	ion		_	16b.	Kind of B	usiness/in		
(Specify only highest grade	completed)		(Give k	ind of wor O NOT us	k done du	ring mos	t of work	ring				•	
Elementary/Secondary (0-12)	College (1-4or 5		ome	stic	2					None	9		
17. Father's Name (First, Middle, Last)					-	8. Mothe	er's Nam	e (First, Middle	, Maide	an Sumar	ne)		
Harry Toadvine						Add	lie	Anders	son	Toa	advir	ne	
19a. Informant's Name/Relationship (Typ	e, Print)	19b.	Mailing	Address	(Street an			al Route Numb		-			
Philip Dashiell	(Nephew	s) 19	936	Fox	hour	nd C	t.s	evern.	Md	.211	44		
20a. Method of Disposition	•	20b. Place of	Dispos	ition (Nan		-		Date		-	- City or To	own, State	
1 Burial 2 Cremation 3 Re 1 Donation 5 Other (Specify)	moval from State	1 .	_	ry (1	0-2	2-05	Fr	uit1	and,	.Md.	
21. Signature of Funeral Service License	8	100 To	and the second second					Home			·uiiu	110.0	
Heady B. S.	townst		8	21 V	lest Vest	Rd.	Sal	isbury	7 . M	d.21	801		
23a. Part1. Enter the disease, or complic	ations that caused	the death, Do n										Approximate Interval Between	
shock, or heart failure. List only one Immediate Cause (Final	a cause on each III	ne.	1	1/2	1	1-		7.				Onset and Deat	
disease or condition resulting in death) a.	Due to lores	a consequence of	70	00-	100	von	~	O cal	02		y	1000	
	10 (0123	2 Sen	<i>J</i> 1.								1	106.	
Sequentially list conditions, b.	Due to (or as	a consequence of	of):								7	lan-	
cause. Enter Underlying Cause (Disease or injury	6/2 /	2	2 -	(A.	00	7				1	10111	
that initiated events c. resulting in death) Last	Due to (or as	a consequence	of):	7 /	00	rate to						2007	
d											0		
		-											
IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome									23d. Da	ate of delive	ery	
in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at	2 Fetal death time of death		Ectopic pr Other <i>(sp</i>						Mo	onth	Day Year	
9 Unknown	9□ Unknown								į				
Part II. Other significant conditions conf	tributing to death b	ut not resulting in	the un	derlying c	ause giver	n in Part I		23e. Did	tobacco	use con	tribute to t	he cause of death	1?
								1 🗆	Yes	2 🗆 No	3 🗀 Prot	oably 4 Onkr	nwor
								24a. Was	an	24b.	Were auto	opsy findings avai	lable
								auto		1	death?	opsy findings avai impletion of cause	e of
05.14								1 ☐ Yes	201	₹o	1 🗌 Yes	2 □ No	
25. Was case referred to medical examiner?	ospital:				Other		/	th (Check only		- Ca	(C :		
1 Yes 2 No	1 🗆 Inpatie		tpatient ime of		8c. Injury	4 4	ursing Ho	ome 5 Resi				(y)	
1 ☑ Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	y Year)	njury	M	Work	es 2	No	230. 2000100	.10# 11	, o. , o.			
3 Suicide 4 Homicide 6 Could not be determined	28e. Place of In	jury - At home, fa ic. (Specify)	rm, stre	et, factory	, office			28f. Location (City or To	Street wn, Sta	and Numi	ber or Rura	al Route Number,	

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

WITLIAM ROBINS, M.D.
31. Date filed (Month Day, Year) 2 0 2005

00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

ORIGINAL

200 CIVIC AVE., SALISBURY, MD. 21804

Sparte

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Deborah Edun 05-7280 AKG

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

-7280)	•	State of Mar State Amend Item 20b-c&Unpend Registrar	yland/Depa Item 23a <i>Cer</i>	utment of H 27 per me tificate of l	lealth,and <u>Me</u> Death	ntal Hygie! Rog. I	2 005	35546
	Physici	20	1. Decedent's Name (First, Middle, Last)			2	. Date of Death		3. Time of Death
1	/Medic	al	Deborah Denise Ed	un	th City Town or	Location of Death		8, 2005	4:17 P M
	Examin	er	Howard County General Hospi	tal	Columbia			Howard	
181	Funeral	3	5. Social Security Number 6. Sex 7. Age (10 M 20) 7. Age	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days		Date of Birth (Month, Day, Yea		nplace (State or Foreign untry)
849	* Director	1	Usual Residence of Decedent			<u>M</u>	arch 22,	1966 Phi	llipeans
	anylan show	<u>_</u>		IOc. City, Town or Lo	cation				10d. Inside City Limits 1 Yes 2 No
	the M	Director	Maryland Howard	Columbia	10f. Zip Code		10g.	Citizen of What Co	•
	h with		8996 Sidelong Place		21045	5		USA	,
	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "natural", or Itama 23s or 28s-f ehow other traumatic event, the Medical Exercities must be motified at	Funerai	11. Marital Status 12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of H	ispanic Origin? (Speci an, Mexican, Puerto Ric	y Yes or No- can, etc.)	14. Race - Ame Black, White	
36	irs afte	by Fi	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify:	Black
5-0036	72 hou natura lical E		15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupa	ation during most of working	16b	Kind of Business/	
2121	net. hen "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	DO NOT use retired	1)		two Two	a a i t
d 2	filed v Hygie other t		17. Father's Name (First, Middle, Last)	Mech	anic	18. Mother's Name (i			nsit
/lan	uld be Jental rked c	To Be	Freddie Lee Johnson, Jr	•		Ilar	Doris Ha	tcher	
Maryland	2 sho and f is ma		19a. Informant's Name/Relationship (Type, Print)			and Number or Rural F			
	1 and Health em 27		Carolyn Cunningham / Sister	20b. Place of Dispo	sition (Name of	., Ft. Was		Maryland Location - City or	
Baltimore,	Pages ment of B ant: If its ury or o'		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Columbia i unk		11-07-	2005	umbia, Ma	ryland
Balt	permit. Page Department of Important: If any injury or once.	0.3	21. Sign rure of Funeral Service Licensee	d 33	Mame and Addressennie Smi 26 Dover	ith Funeral St. Easton	Home , Maryla	nd 21601	
	Physician /Medical Examiner	ner	disease or condition resulting in death) a. Dilatation Due to (or as a	aly With I		g, such as cardiac or r	-	y And	Approximate Interval Between Onset and Death
68760,	ficate be executed physicien and is the burial-transit	edicai Examin	that initiated events c.	consequence of):					
P.O. Box (it the death certi by the attending tached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Xes 2 ☐ No 9 XUhknown 23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tii 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	1		23d. Date of deli Month	overy Day Year
ords, F	quires tha in signed uld be de	by	Part II. Other significant conditions contributing to death but	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tobacc	i	the cause of death?
al Reco	sician: The law requii certificate has been s rector, page 2 should	Completed					24a. Was an autopsy performed 150 Yes 2	prior to o death?	topsy findings available completion of cause of
55	ysicial is certii directo	o Be	25. Was case referred to medical examiner? ¹X Yes 2 □ No Hospital: 1 □ Inpatient	2 X ER/Outpatien	nt 3 DOA Oth	er: 4 Nursing Home		6 ∏Other (Spec	zifv)
36	Attending Physician: r death. sctor: Atter this certifici by the funeral director.	tion: T	27. Manner of Death 1 Natural 5 Pending (Month, Day)		f 28c. Injun Wor		d. Describe how in		,
 Division	9 fg ⊆	Certification:	3 Suisido 6 Could not be	y - At home, farm, str (Specify)			f. Location (Street City or Town, St	and Number or Ru ate)	ral Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edicai (29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Exeminer: On the basis of e and manner state	xamination and/or in					
	To the within To the comp	Me	29b. Signature and, liftle of certifier		29c. Licens OCM		29d Oc	Date signed (Monti tober 29	n, Day, Year) , 2005
	0		30. Name and address of person one completed cause of dea	ath (Item 23a) (Type,	Print) 111 P	enn Street	Baltim	ore, Mary	land 21201
	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar	's Signature	2 0~				

ORIGINAL

			For State Registrar	State of Ma	aryland /			nt of He <i>te of E</i>		d Mental	Hygie Reg.	2 0 0	5 (35547
		1.3 27.8	1. Decedent's Name (First, Middle, Las	t)						2. Date	of Death	Day	Vaaa	3. Time of Death
	Physici /Medio		Theresa	М. Н	Ellis							Day 21, 20	Year 05	1:20 p.m.
	Examir		4a. Facility Name (If not institution, give	street and number)			4b. City	, Town, or	Location of De	eath		4c. County	of Death	
1		Acr .	St. Mary's N	ursing Cer	iter			Le	onardt	own		St	. Ma	ry's
	Funeral		Social Security Number 6. S		e (In yrs. iast		If Unde	er 1 Year Days	If Under 24 H	Irs. 8. Date	of Birth th, Day, Ye	ar)	9. Birthp	lace (State or Foreign try)
	Director		236-16-9881	□ M 2 F	86	Yrs.	TVIOTILITIES	04,5	1100.0		15,			
	D >		Usuat Residence of Decedent 10a. State 10b. County		10c. City, T	oum or Lo	ontine						1	0d. Inside City Limits
	aryla ehov	<u>_</u>			Toc. City, 1	OWIT OF LO	Cation						'	1 ☐ Yes 2 No
	Ba-f	cto	Maryland St. Ma	ry's					nicsvi.	11e				
	ith th	Director	10e. Street and Number				10f. Z	ip Code			10g.	Citizen of W	hat Cour	try?
	ath v	ra ra	39398 Golden					206				United		
36	72 hours after death with the Maryland natural; or itams 23a or 28a-f show alsal Examinat must be mailfied at	y Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Armed Forces? 1 Tyes 2 If Yes, Give		'	Was Dec f Yes, sp 1 ☐ Yes	ecify Cuban	panic Origin? , Mexican, Pu Specify:	(Specify Yes Jerto Rican, et	or No-		k, White,	an Indian, etc. ite
21215-0036	72 hours "naturs!"	Completed by	3 ∰Widowed 4 □ Divorced	Year or Dates:							1			
7	"natur	iete	15. Decedent's Ed (Specify only highest gra	ucation de completed)		(Give	kind of w	ual Occupation de	tion uring most of i	working	168	o. Kind of Bu	siness/Ind	dustry
12	within ene. then	m D	Elementary/Secondary (0-12)	College (1-4or 5	5+)		_					ъ.		
	77 70 10 10		17. Father's Name (First, Middle, Last)			Sa	lesp	erson	18 Mother's f	Name (First, A	Aiddle Mai	Reta		
and	e c a c	Be							10. 141011101 3 1	Marie			5)	
2	should be nd Menta marked umatic so	٥	John Greco 19a. Informant's Name/Relationship	Supp. (Grint)	T.	10h Mailie	a Addra	na (Stroot o	nd Number or	Rural Route			Ctate Zin	Cadal
Maryland	id 2 shouth and 27 is my													
	s 1 and 2 should if Health and Men item 27 is marks other traumatic	1	Nickie Eugene Dot 20a. Method of Disposition	tellis / S	20b. Place	e of Dispo	sition (N	ame of		oad, Me		LCSV11 Location -		MD 20659 wn State
Baltimore,	0 = 0		1 Burial 2 Cremation 3		cem	etery, cren	natory or	other place	1					
Ë	permit. Pag Department Important: f any injury o		4 □Donation 5 □Other (Specify		-Brins					-28-200				
3al	permit. Departm Importa any inju	1	21. Signature of Funeral Service Licer	17.11	Low									me, P.A.
100	70 F = 0		Kyle S. Simo	0.22	M01206			-					MD	20650-0279
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	olications that caused one cause on each li	the death. [ne. RESA	Do not ent	er the my	ade of dying	such as care	diac or respira	tory arrest,	•		Approximate Interval Between Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as	a consequen	ice of):	- 19	rea	n Fr	alu.	N			urb
	P =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequen	ice of).		-A-						\ \ \ \
	icate be executed physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	с.	102	m	21	int	2					42
oʻ	e exe an al urial-1	m X	resulting in death) Last	Due to (or as	a consequen	ice of):		J						(I - I)
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		Jed	IE EENAALE.								_			
Вох	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1☐Live birth			Ectopic	pregnancy				23d. Date		•
	the att	100	in the past 12 months? 1 ☐ Yes 2 █ No	4☐Pregnant at 9☐Unknown			Other (Mon	ith	Day Year
P.0	tached	hys	9 ☐ Unknown	9 Onknown										
	res tha igned to be det	by	Part II. Other significant conditions of	ontributing to death b	ut not resultin	ng in the u	nderlying	cause give	n in Part I.	23е	. Did tobac	co use contri	ibute to th	e cause of death?
Vital Records,	w require been signal									_	1 🗆 Yes	2 🔁 No	3 🗌 Prob	ably 4 □Unknown
8	awre s be 2 sho	Completed								24a	Was an	24b. W	ere auto	osy findings avaitable
Ä	The Late ha	Eo								_	autopsy performed Yes 2	i? d	eath?	πptetion of cause of 2∰ No
tal	ilcian: Th certificate rector, pag	0	25. Was case referred to medical						26. Place of I	Death (Check		INO I		248 140
>	Physician: this certificatal director, I	OB	examiner? 1 ☐ Yes 2 █ No	Hospital: 1 ☐ Inpatie	ent 2 ER	VOutpatien	nt 3 🗆 🖸	Othe Othe	e 1515	g Home 5□		e 6 🗆 Othe	r (Specifi	<i>(</i>)
o	19 Ph	T.	27. Manner of Death	28a. Date of Inju (Month, Da		3b. Time of		28c. Injury Work				njury occurre		,
jon	E +5 5	atio	1 ■ Natural 5 □ Pending 2 □ Accident investigation		y rear)	Injury	М		es 2∐No					
Division	ii or Attendii after death. I Dirsctor: A d in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of in	ury - At home c. (Specify)	e, farm, str	eet, facto	ory, office		28f. Loca City	ition (Stree or Town, S	t and Numbe itate)	or Rura	l Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best niner: On the basis o and machier st	f examination	edge, death n and/or in	n occurre vestigation	d at the time on, in my op	e, date and pl	ace, and due courred at the	to the caus time, date	e(s) and mar and place, a	nner as st	ated. the cause(s)
	To th Withir Fo th	Me	29b. Signature and title of certifier	1)//	1)	14	/ 2	9c. License	number		29d.	Date signed	(Month,	Day, Year)
	(e/		h la	1911 10	DIME	= N1	1	I	DA	419		10	25-	05
3	\$ 0		30. Name and address of person who	completed cause of	death (Item 23	3a) (Type	Print)		00	4		100		
	,		J. Patrick Jarbo	- M D// 3)/02F m	m1		ch Ro	ad. Ho	11 v wood	. Mar	rvland	206	36
	Sta	ate	31. Date filed (Month, Day 1797)	8 2005 Regis	ar's Signature	0		J 100		,	. ,			
1	Regist	rar	1 001 2	U CUUJ I	The same of	M	A.							

Xavier Epps, Jr. Amend/Unpend item#1,23a,27,28a-f, perME,G850,1Z-23-05 The State of Maryland / Department of Health and Mental Hygiene () 5 05-07244 crn 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last)
Xavier Epps, Jr. 2. Date of Death 3. Time of Death **Physician** -Xavvier 26, 2005 2:52 P^{M} October 0 Epps /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Center Cheverly Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 **XM** 2 ☐ F Months Director 12/28/2004 578-39-3239 28 Wash.D.C Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location or 28e-f show 10d. Inside City Limits the Madical Examinar must be notified at Director Yes 2 No MD Prince Georges District Heights 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 238 1952 Rochelle Ave U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: ρ Specify: Black 3 Widowed 4 Divorced natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) none 0 none 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Palmatto Wynn ပ္ Xavier Epps Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Importent: if Item 27 la any injury or other treu 1952 Rochelle Ave.Dist.Hgts.MD.20747 Xavier J. Epps Sr./father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Resurrection Cem 4 ☐ Donation 5 ☐ Other (Specify) 10/31/05 Clinton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges and Edwards 3910 Silver Hill RD. Suitland, Md Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Sudden Unexplained Death in Infancy /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (vi as a consequence of) sicien and e burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the s 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? 2 No 2 No or Attending Physician: 25. Was case referred to medical exeminer?
1 Yes 2 No Certification: To Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury Fnd (Month, Day Year) 28b. Time of Fnd 28c. Injury at Work? 28d. Describe how injury occurred unk 5 Pending investigation 1 Natural after death.

I Director: Af
d in by the fur 2 Accident 2:00 P 1 ☐ Yes 2xxXNo 10-28-05 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)

found at home filled in by 28f. Location (Street and Number of Rural Route Number, City or Town, State) 1952 Rochelle ave 4 Homicide within 24 hours a #623 District Heights, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

26 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Torsha Lel O.C.M.E. October 27, 2005

State Registrar 31. Date filed (Month, Day, Year)

NOV 2 3 2005

Larenbera

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

		-	For State Registrar	;	State of	Marylan				lealth ar <i>Death</i>	nd Mei		giene Rog. No	000	3554	9
*			Decedent's Name (First, Middle	, Last)							2.	Date of Dea	ath Da	v Year	3. Time of 0	Death
**	Physici		O)1 T-1-		E':	roat					()ct.		2005	8:55	M
	/Medic Examin	4	Charles Lit 4a. Facility Name (If not institution	1003 give sti	reet and num	ber)		4b. City	, Town, o	r Location of				. County of Dea		<u></u>
- 1	Examin	ei							Cli	nton			Pı	rince (George'	S
	Funeral	*	Southern Mary 5. Social Security Number	6. Sex	id HO	7. Age (In yrs.	iast birthday)		r 1 Year	II Under 24		Date of Birt (Month, Da	th		hplace (State or ountry)	
	Funeral Director		233-42-0672	1	M 2 🗆 F	77	Yrs.	Months	Days	Hours	Min.	2/26/			WV	
A - 1			Usual Residence of Decedent									1			,	
	land ow		10a. State 10b. County			10c. Cit	ty, Town or Lo	cation							10d. Inside City	•
	Man	ō	MD Princ	a G	anrae	1 0			Sui	tland	ą.				¹₹ Yes	2 🗌 No
	158 28 a	Director	10e. Street and Number	<u> </u>	COLGC	<u> </u>		10f. Zi	p Code	01011			10g. Ci	tizen of What Co	ountry?	
	with so or	ā	0505 5			D	_		2	0746				USA		
	within 72 hours after death with the Maryland ene. then "netural", or items 23e or 28e-f ehow the Marical Exard or most the motified at	Funeral	3505 Parkway	Tel	rrace 2. Was Dece	Drive dent Ever in U	J.S. 13.	Was Dece	edent of H	lispanic Origi	in? (Specif	y Yes or No	-	14. Race - Ame		
	iter d	Ë	1 ☐ Never Married 2 ☐ Marr		Armed For	ces?		If Yes, spe	ecify Cuba	an, Mexican,	Puerto Rio	can, etc.)		Black, Whit	e, etc.	
36	rs af	by	3 ☐ Widowed 4 ☑ Divorced		1 V Yes If Yes, Give Year or Da	entes: 54 – 5		1 🗆 Yes	2 No	Specify:				Specify:	White	
21215-0036	hou tura		15. Deceden	's Educa		54-5	16a. Dece	dent's Usu	ual Occup	ation			16b. K	(ind of Business		
<u>ب</u>	"na	Completed	(Specify only highes	t grade	completed)		(Give	kind of w	ork done	during most of	of working					
12	with:	Ĕ	Elementary/Secondary (0-12)		College (1-	-4or 5+)	Flec	tric	a1 1	echn:	icia	n	E1e	ctric	Compan	v
N	Hygid Hygid Sther		17. Father's Name (First, Middle,	Last)			111100	OLIC	<u> </u>			First, Middle,				
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₹	Mer Merk Merk	ို	Claude Frost		a Oriet)		10b Mail	na Addres	c /Stroot			Kinse		or Town, State,	Zin Code)	
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ore	of H of H if ite		20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation	3 □Re	moval from S		cemetery, cre	matory or	other pla	ce)			200. 0	oution only of	, , , , , , , , , , , , , , , , , , , ,	
altimore,	permit. Pages 1 Department of H Important: if ite any injury or ot once.		4 □ Donation 5 □ Other (S	pecify)			esape	ake	Cre	m. 1	0/11	/05	Be	ltsvil.	le, MD	
att	Departr Mports Imports In Inj		21. Signature of Funeral Service	License	-		2	2. Name a	and Addre	ss of Facility	Rav	mond-	-Woo	od Fune	eral Ho	ome
0	88 = 58		1. (N)	ov.	/		P	O Bo	ox 4	30, D						
2	7		23a. Part1. Enter the disease, or shock, or heart lailure. List	complic	ations that ca	aused the dea	ith. Do not en	ter the mo	de of dyn	ng, such as c	ardiac or r	espiratory a	rrest,		Approximate Interval Betv	ween
	Physician		Immediate Cause (Final	o, o	Λ.		MYOCI	222.	1.	14154	100	Tioni	,		Onset and E	Jeath
6	/Medical		disease or condition resulting in death)	_ a.	Due to (or as a conse		4KD1	MZ	TIVPI	nac	(1010				
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	xecu and	Ха	resulting in death) Last	C.	Due to (or as a conse	quence of):									
8760	cate be executed physician and the burial-transit	aiE		L.												
	phy:	dical		a.												
9 ×	The law requires that the death certifit ate has been signed by the attending t page 2 should be detached for use as	Me	IF FEMALE:	25	Ro If was out	come of pregr	nancy							23d. Date of de	livery	
Вох	ath c	lan	23b. Was decedent pregnant in the past 12 months?		1☐Live b	irth 2 ☐ Fet ant at time of	al death 3	□Ectopic □ Other (s		У				Month		rear
<u>.</u>	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9☐ Unkno		Geatti 5	_ Other (s	specify/_							
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	es the	þ	CONSESTIV		-				ouuso gi	VOI. 11.1 2.1 1.		1	Yes 2			Jnknown
ğ	w require been si should	Completed	CONPERIO	<u></u>	HE HA	-11	TITEO	1-0					100 2			
ပ္ထ	e law r has be je 2 sh	ple										24a. Was	DSV	prior to	utopsy findings a completion of ca	available ause of
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ta		BeC	25. Was case referred to medica	ı						26. Place	of Death (Check only	one)			
>	Physician: r this certified ral director, I	To B	examiner?	Н	ospital:	Inpatient 2	ER/Outpatie	ent 3 🗆 🛭	DOA Ot	her: 4 🗆 Nur	rsing Home	e 5 ☐ Resi	idence	6 ☐Other (Sp.	ecify)	
ō	ding Physician: h. After this certific funeral director,		27. Manner of Death		28a. Date	of Injury th, Day Year)	28b. Time	of	28c. Inju	iry at	28	d. Describe	how inju	ury occurred		
o	Aft.	9	1 ☑Natural 5 ☐ Pendi 2 ☐ Accident invest	ng igation	(MOI)	iii, Day 10ai)	Injury	M		Yes 2□N	No					
/isi	dea dea octor	fice	3 ☐ Suicide 6 ☐ Could			of Injury - At		treet, facto	ory, office		28				Rural Route Num	iber,
Division of Vital Records,	after after Director	Certification:	4 Homicide		buildi	ing, etc. (Spec	eny)					City or To	iwii, Sta	(0)		
	To the Hospitei or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifyi	ng Phys	ician: To the	best of my kr	nowledge, dea	ith occurre	ed at the t	ime, date and	d place, an	nd due to the	cause(s) and manner a	is stated.	
	24 h 24 h Fur etely	Medical	(Check only 2 Medica	Examir	er: On the b	asis of examin	nation and/or i	nvestigatio	on, in my	opinion, deat	th occurred	d at the time,	, date ar	nd place, and du	e to the cause(s	;)
	thin thin omple	Me	29b. Signature and title of certific	er .				2	9c. Licen	se number			29d. D	ate signed (Mor	nth, Day, Year)	
\	8 H E H	1	1 - DRIV						DY	0324			OCT	OBER	3, 2009	5
			7300			and dense de	-m 03a\ /T-						-		-	
	1-VA		30. Name and address of person			se or death (Ite	ern ≥3a) (Type	ATT	R	OAD	CLI	NTON.	MA	ARY LAN	D 207	3
					32 5	Panista de Sina	nature	-11// -2	, /	,,,,		1				-
/	St	ate	31. Date liled (Month, Day, Year		2005	Registra 's Sign	es K	do	we	•						

			1 - For State Registrar	State of I	Maryland		artment rtificate			and M		giene Reg. No.	005	35	550
	Physici	an	1. Decedent's Name (First, Middle, La.	•							2. Date of Dea	ath Dav	Year		e of Death
	/Media	cal	Joseph Louis Fis		-)						october		200		35 M
	Examir	er	4a. Facility Name (If not institution, given Anne Arundel Med		-				Location o	f Death		140	ounty of Dea		
			5. Social Security Number 6. S		Age (In yrs. Ia.	et hirthday)	Ann a	*	LS If Under 2	24 Hrs	8. Date of Birt		e Aru		4
Н	Funeral Director		302-14-3453	⊠ M 2□F	80	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Day Sept.	17,	مماء ٥	nnplace (Sta lountry) Oh10	te or Foreign
	pu 🔏		Usual Residence of Decedent 10a. State 10b. County		100 City	Town or Lo									
	within 72 hours after death with the Maryland ene. then "natural", or Items 23a or 28e-f show ha Modfall Exa. itrer: wat be notified at	ō	Maryland Anne Ar	undel	-	napoli									e City Limits fes 2 ☐ No
	r 28e-	Director	10e. Street and Number				10f. Zip	Code				10g. Citize	n of What C	ountry?	
	h witt	a D	105 Simms Drive				21	401				Unit	ed St	ates	
	deat	Funeral	11. Marital Status	12. Was Decede Armed Force		. 13.	Was Deced	ent of Hi	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	. 14	. Race - Am		1,
36	be filed within 72 hours after dea ntal Hygiene. sd other then "natural", or Items event, Ite Madical Examiliation		1 Never Married 2 Married	1 Yes 2	□No		1 ☐ Yes 2		Specify:	, ruento r	vicari, etc.)		Black, Whi		
21215-0036	hour tural	Completed by	3 🖫 Widowed 4 □ Divorced 15. Decedent's Ed	Year or Date	WWII	16a. Deced	lent's Heur	1 Occupa	ation		1		pecify: wh		
215	n "na	piet	(Specify only highest gra	de completed)	25.	(Give	kind of wor DO NOT us	k done o	luring most)	of working	g	TOD. KING	or business	vindustry	
212	filed with Hygiene. other ther	mo	Elementary/Secondary (0-12)	College (1-4d 5+	or 5+)	Res	earch	Eng	ginee	r		Fede	ral G	overnm	ent
pu	be filed tal Hygie d other event, II	Be (17. Father's Name (First, Middle, Last)								(First, Middle,	Maiden S	umame)		
yla	should be filed within the Mental Hygiene. marked other then matic event, II.u.M.	2	Joseph Fischer							en Dy					
, Maryland	od 2 s Ith ar 27 is r treu		19a. Informant's Name/Relationship (Steven Fischer/ s								Route Numbe			Zip Code)	
Baltimore,	0 0		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 1)		ite cer	ce of Dispo- netery, cren crest	natory or ot	her place	· 1		2-2005		ition · City or		
Baltii	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licer		Sli	22	. Name and	d Addres	s of Facility	Johr	M. Ta	ylor	Funera	al Hom	e, Inc
			23a. Part1. Enter the disease, or com	plications that cause	sed the death								poris	Approxir	
	Prysician :		shock, or heart failure. List only Immediate Cause (Final	one cause on each	veza)	VW		g, such as c	cardiac or	16spiratory an	1621,		Interval I Onset ar	Between nd Death
	/Medical		disease or condition resulting in death)	a	as a conseque			0						16	mos
	Examiner			·	as a solicoque										
1	p =	ner	Sequentially list conditions, in any, leading to immadate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Oue to (or	as a sonseque	i ta Jij.									
	and trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	C											
68760,	cate be executed physician and the burial-transit	ai E		DUB 10 (01	as a conseque	ince oi):									
587		edicai		. d											
Вох	death certific e attending p id for use as	υ/Μe	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor								230	d. Date of de	livery	
	0 0 0	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown		2 □ Fetal d t at time of dea 1		Ectopic pre Other (spe						Month	Day	Year
٦.	that the		Part II. Other significant conditions of	ontributing to death	n but not result	ing in the un	nderlying ca	use give	n in Part I.		23e. Did to	bacco use	contribute to	o the cause o	of death?
rds,	w requires that the been signed by th should be detache	ed by									1.2(Y	es 2 🗆 I	No 3∏P	robably 4	□Unknown
9	aw as b 2 si	ompieted									24a. Was a		24b. Were at	utopsy finding	gs available
	The ate h page	Com									autops perfor	med? 2-X No	death?	completion o	ir cause or
Vital	Physicien: The this certificate ral director, pag	Be (25. Was case referred to medical examiner?							of Death	(Check only or				
of	S 0 0	P	1 195 243 190	Hospital: Inpa		R/Outpatient		-	4 🗆 1401	sing Hom	e 5 ☐ Resid	ence 6 [Other (Spe	cify)	
	ding h. After fune	ertification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		Day Year) 2	8b. Time of Injury	м 28	lc. Injury Work 1 □ Y	at ? ′es 2 □ N		3d. Describe h	ow injury o	ccurred		
Division	or Attending after death. Director: After in by the fune	ifica	3 Suicide 6 Could not be	28e. Place of	Injury - At hom	e, farm, stre					3f. Location (S	treet and h	lumber or Ri	ural Route N	umber,
	- 9 -	Cert	4 Homicide	building,	etc. (Specify)						City or Tow	n, State)			
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	edical	29a. Certifier 1 Certifying Physical Check only one) 1 Medical Exemption	ysicien: To the be liner: On the basis and manner	ot examinatio	edge, death n and/or inv	occurred a estigation,	t the time in my op	e, date and inion, death	place, ar	nd due to the c	ause(s) an	d manner as ace, and due	stated. to the cause	e(s)
	To th within To th comp	Me	29b. Signature and title of certifler	nı ,				License		. ~			igned (Mont		
			XLM S' (Nel	dem d	~				8 1						005
			30. Name and address of person who of STANLBY WA	completed cause o	f death (Item 2	3a) (Type, F	Print)		1		2				
			STANLEY WA	TKIMS	700	0 1313	28761	17/12	160	10	NNON	UIS.	mo z	1401	
\$ 5	Sta Registr	1	31. Date filed (Month, Day, Year) OCT 2 0 200	Regi:	strar's Signatur	Ina	Sh)								

JOHN HOWARD THAYER FRANCIS

			1 = For State Registrar	State of Ma		epartment of I Certificate of		Mental Hy	20	05	35551
			Decedent's Name (First, Middle, La	ist)		ortinoato or	Death	2. Date of D	Reg. No.		3. Time of Death
	Physic		John Howar	d Thaver	Franc	ia		Month Octobe	Day	2005	5:41 p.n
	/Medi Exami		4a. Fecility Name (If not institution, give		Franc		or Location of Death			unty of Death	J.41 P.III
1	19		St. Mary's H	lospital		T	eonardtow	m		. Mary	, , ,
	Funeral		5. Social Security Number 6. 5	Sex 7. Age	(In yrs. last birtho	ay) If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	irth		place (State or Foreign ntry)
	Director		024-50-7332	1 2 M 2 □ F	47 Yrs	Months Days		(Month, D March 1			Hampshire
	put		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Logotion					
	sho	2	,		roc. Oity, rowird						10d. Inside City Limits
	he M	Director	Maryland St. M	lary's		Hollywood					1 Yes 2 No
	with t	늅				10f. Zip Code			-	of What Cou	•
	s 23	era	25350 Pinto	Drive 12. Was Decedent Ev	es is U.C.		0636			ed Sta	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. item 27 Is marked other then "neturel", or Items 23s or 28s-f show other treumetic event, Its Modical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ∰ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ∰ Yes 2 ☐ No If Yes, Give Year or Dates:		3. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☑ No		ecify Yes or No Rican, etc.)	1	Race - Americ Black, White, ec <i>ify:</i> Wh	
Š	2 hou	ted	15. Decedent's E	ducation	16a. De	ecedent's Usual Occup	pation		16b. Kind o	of Business/In	dustry
215	within 7; ene. then "n	Completed	(Specify only highest grant Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(G	ive kind of work done e. DO NOT use retire	during most of work	aing	700. Kind (Ji Dusii 1633/111	dustry
21	filed withi Hygiene. other then	E O	12	College (1-401 5+)		OA Inspect	or		Gover	nment	Contractor
	if Hygie other	a)	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle			Concractor
<u>a</u>	should be fand Mental Hammarked of	ToB	George Wilso	n Francis			J	anet Sa	rgent		
Maryland	2 should be filed within and Mental Hygiene. Ie marked other then eumetic event, ITB M.	•	19a. Informant's Name/Relationship (Type, Print)	19b. M	ailing Address (Street				wn, State, Zip	Code)
	Health tem 27 l		Virginia Guy Fra	ncis / Wife	253	0 Pinto D	rive, Hol	lywood,	Marv1	and 20	636
Baltimore,	ges 1 ar t of Hea if item		20a. Method of Disposition	30	20b. Place of Di	sposition (Name of crematory or other pla	ce)	Date		on - City or To	
Ĕ	permit. Pages 1 Department of H Importent: If ite any injury or ot		1 ■ Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Special			ge's Epis	1	8-2005	Valle	v T.ee	Maryland
alti	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Lice	nsee	1000	22. Name and Addre	ess of Facility Br	insfiel	d Fune	ral Ho	me, P.A.
m	8 3 E 5 8		Edward N. Brinsfi	eld, Jr.	M00052	22955 Holl					•
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused th	e death. Do not						Approximate
	Physician		Immediate Cause (Final disease or condition			um d a					Interval Between Onset and Death
	/Medical		resulting in death)	w	dysrhtl	ımıa					minutes
	Examiner				,						
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a d	consequence of):						
	te be executed ysician and ie burial-transit	Examiner	that initiated events	C.							
oʻ	an ar	EX	resulting in death) Last	Due to (or as a o	consequence of):						
68760,	ficate be physici is the bu	edical		d							
	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit		IF FEMALE:								
Вох	eath certiff attending I for use as	Physician/M	23b. Was decedent pregnant	23c. If yes, outcome of		3 □Ectopic pregnancy	J.			Date of delive	ery
O.E	ed fo	sici	in the past 12 months? 1 Yes 2 No	4□Pregnant at tin		5 Other (specify)				Month	Day Year
P.O.	at the de I by the a stached	2hy	9 Unknown								
	res tha igned i	by I	Part II. Dther significant conditions of				en in Part I.	23e. Did t	obacco use c	ontribute to th	e cause of death?
ord	en s	ted	Recent acute	myocardial	intarct	ion		1 🗆 '	Yes 2□No	3 Prob	ably 4 Unknown
of Vital Records,	e faw re has be	Completed						24a Was		b. Were autor	psy findings available appletion of cause of
H	Th ate pag	Con						perfo	rmed?	death?	
/ita	Physicien: The this certificate ral director, page	Be (25. Was case referred to medical examiner?				26. Place of Death				
<u></u>	d is	2	1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpat	rent 3 DOA Oth	er: 4 🗆 Nursing Ho	me 5 Resi	dence 6 🗆 (Other (Specify)
L	ding P	on:	27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day Y	ear) 28b. Time		y at k?	28d. Describe I	how injury occ	curred	
Division	Attending r death. sctor: After by the fune	Certification:	2 ☐ Accident investigation				Yes 2 □ No				
Ξ	of or Attend after death Director:	ţį.	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm, Specify)	street, factory, office		28f. Location (3 City or Tox	Street and Nu	mber or Rural	Route Number,
Ω	itel or rel D	Cer						,	,,		
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying Ph	ysician: To the best of r	ny knowledge, de	ath occurred at the tin	ne, date and place,	and due to the	cause(s) and	manner as sta	ated.
	the f	led		and manner stated	d.			ed at the time,	date and plac	e, and due to	trie cause(s)
	Sol With	Σ	29b. Signature and title of certifier			29c. Licenso			29d. Date sig	ned (Month, L	Day, Year)
•			Cle M	0		D54	650		Octobe	r 22,	2005
			30. Name and address of person who								
			Michael Cetta,			ookout Roa	ad, Leonar	dtown,	MD 20	650	
	Sta		31. Date filed (Month, Day, Year) OCT 2 5 2	005 32. egistrar's	Signature	had a					
	Registr		11011 Z 0 Z		15 1	·					
DHI	VIH 17 Rev 1/20	001	arm		\ 7.						

			For State Registrar	e of Maryland		tificate of L		R	leg. No.	J	33332
	Physicia	an	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Dev	Year	3. Time of Death
	/Medic	al	Hale S. Friedenberg 4a. Facility Name (If not institution, give street an	d number)		4b. City, Town, or	Location of Death	Octobe	4c. County of		4:20 A M
	Examin	er	Hebrew Home of Grea		ton	Rockv			Mont		ery
*	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth	Vegr	9. Birthr	place (State or Foreign
	Director		579-38 - 9732 ¹ X ^M ^{2□}	¹ F 7	9 Yrs.	Months Days	Hours Min.	Dec. 4,	1925	Mici	nigan
	and *		Usual Residence of Decedent 10a. State 10b. County	10c. City, 1	Fown or Lo	cation					Od. Inside City Limits
	Maryli	lor	Maryland Montgomery	Rock	ville						1X Yes 2 ☐ No
	r 28a	rec	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Cou	ntry?
	th with	Funeral Director	6121 Montrose Road			20852			U.S.	Α.	
	ems erri	ıner	Amo	Decedent Ever in U.S. ed Forces?	13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Si	pecify Yes or No- Rican, etc.)	14. Race Black	- Ameri	can Indian, etc.
20	s afte	by Fu	If Vo	Yes 2 □ No Navy s, Give ·or Dates: WW 2	1	☐ Yes 2X No	Specify:		Specify:	Wh:	ite
3	filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or Items 23a or 28a-f ehow ent, the Medical Examiner must be notified at	ed t	15. Decedent's Education		16a. Deced	ent's Úsuai Occupa	ation		16b. Kind of Bus	iness/In	dustry
9500-61212	thin 7.	Completed	(Specify only highest grade completed in the complete state of the	ege (1-4or 5+)	life. L	kind of work done a OO NOT use retired,	uring most of wor)	king	Food Wh	oles	sale
7	ygien ygien ygien ygien ygien t. Ibe	Соп	12 Years		Merc	hant	40.14.0	(Fine a 4 and 4)			Lbutor
Maryland	be fill be fill be fill be defined by the below of the be	Be	17. Father's Name (First, Middle, Last) Harry Friedenberg				18. Mother's Nan Ruth S:		Maiden Sumame	1)	
Ξ	should be and Mentat s marked o umatic eve	2	19a. Informant's Name/Relationship (Type, Prin.	0	19b. Mailin	g Address (Street a			r, City or Town, S	State, Zij	Code)
	and 2 s ealth an m 27 ls		Janis L. Datz - Dau			Kerryda:					
e,	of Heal		20a. Method of Disposition	cen	e of Dispo	sition (Name of natory or other place	9)	Date	20c. Location - 0	City or To	own, State
altimore,	Pages nent of l		1 X Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	Jude		m. Garden			Olney, M		
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examener must be notified at once.		21. Signature of Funeral Service Licensee	Tottlemen	Da 11	Name and Address nzansky-0 70 Rockv	s of Facility Goldberg ille Pike	Memoria:	l Chapel	s, l	Inc. and 20852
÷	200		23a. Part1. Enter the diseese, or complications shock, or heart failure. List only one cause	that caused the death.		er the mode of dying					Approximate Interval Between
	Physician	9	Immediate Cause (Final disease or condition	MULT	1-	NFA	RCT	DEMI	ENTIS	1	Onset and Death
	/Medical Examiner		resulting in death)	ue to (or as a conseque	nce of):					•	
3	- Administra	r.	Sequentially list conditions, if any, leading to immediate	ue to (or as a conseque	nce of):					-	
	unsit	Examiner	Cause (Disease or injury that initiated events		,					- 1	
o,	exect an and rial-tra			ue to (or as a conseque	nce of):				-		
8760,	ficate be executed physician and s the burial-transit	dlcal	d								
9	= 0,4	/Med	IF FEMALE: 230 If yo	s, outcome of pregnanc	W.1				00.1.0	-6 -1 -15	
ROX	that the death certific ed by the attending p detached for use as	clan	in the past 12 months?	Live birth 2 ☐ Fetal de Pregnant at time of dea	eath 3	Ectopic pregnancy Other (specify)			23d. Date Mon		Day Year
o.		ysle		Unknown		,					
ري ت	The law requires that the tite has been signed by thoage 2 should be detache	by Physician/Me	Part II. Other significant conditions contributing	g to death but not resulti	ing in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contri	bute to t	he cause of death?
S C	w require been sig should b							1 □ Y	es 2 No	3 🗌 Proi	oably 4 DUnknown
Records,	e law re has be ge 2 sho	Completed						24a. Was autop	sv p	rior to co	opsy findings available impletion of cause of
		Соп		·				perfor		eath?	2 No
Vital	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?			Othe	ar V	th (Check only or			-
	d is	.: To	10 105 2010	Date of Injury 2	VOutpatien 8b. Time of	t 3L DOA	Nursing H	ome 5 Resid 28d. Describe h	ence 6 Othe		(y)
O	nding Ph Ith. :: After th s funeral	atlor	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		k? Yes 2 □No				
Division of	or Atternation designation of the designation of th	Certification:	3 Suicide 6 Could not be determined 28e.	Place of Injury - At hom building, etc. (Specify)	e, farm, str	eet, factory, office	:	28f. Location (S City or Tow	Street and Numbern, State)	r or Rur	al Route Number,
	Hospita 4 hours Funeral ely fillec	Medical Co	29a. Certifier 1 Certifying Physician: (Check only 2 Madical Examiner: On	the basis of examinatio							
	To the within 2 To the complet	Med	one) and 29b. Signature and title of certifier	I manner stated.		29c. License	number	, 1	29d. Date signed	(Month,	Day, Year)
)	64		1100	1111 0	115) 01	808		00100	FR	177014
-	V		30. Name and was of person who completed	cause of death (Item 2	3a) (Typ-	rint)	2	117	0 (4)	0.	1 2003
			DINESH DAT	ELMD.	61	2, 200	trise	Rd, Ke	ck willi	, M	12030
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signatur	ге	este		,		1	-
	Regist	rar	OCT 2 0 2005	Paragrap St.	A. S.						

WILLIAMSPORT NURSING HOME WILLIAMSPORT WASHINGTON If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Yeer) 11/18/1908 9. Birthplace (Stete or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) 1□M 2ÅF Months Days Hours Yrs WEST VIRGINIA 234-01-6185 96 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location an "naturel", or frems 23a or 28a-f show Medical Examiner must be notified at 1**X** Yes 2 □ No WILLIAMSPORT WASHINGTON 10f. Zip Code 10g, Citizen of What Country? 10e. Street end Number 154 N. ARTIZAN STREET 21795 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: WHITE ģ 3XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME Hygiana. HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) . Pages 1 and 2 should be fil tment of Health and Mental H lant: If item 27 is marked ott Be HARRY PERRELL HARRIET HIBBERT 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 3802-B CHARLES STREET, ST. JOSEPH, MO 64501 Department of Health a important: If item 27 is any Injury or other tra MEREDITH DARLINGTON/NEPHEW 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 10/22/ 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State SMITHSBURG CREMATORY SMITHSBURG, MD 2005 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility
BROWN FUNERAL HOME 21. Signature of Funeral Service Licenses P.O. BOX 821, 327 W. KING ST., MARTINSBÚRG, WV 25402 haeles ne 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical . Pneumorria 10 DAYS Examiner Due to (or as a consequence ol): Physician/Medical Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or as e consequence ol) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DEMENTIA HOVANCED SEMILE à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2 0 No 1 ☐ Yes 2 ☐ No 1□ Yes 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To funeral 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Menner of Deeth 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifie D33700 OCTOISEZ 18, 2005 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) WILLIAMSPORT APTIZAN WH-7 LED HOWE 31. Date filed (Month, Day, Year) OCT 2 4 2005 32. Registrar's Signature State Registrar DHMH 16 Rev 6/95 **ORIGINAL**

Piease Type or Print in Black Indelibie Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 005

Day 2005 Year

12:26PM

2. Dete of Death OCT. 18,

4b. City, Town, or Location of Death 4c. County of Death

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State of Maryland / Department of Health and Mental	Hygiere () 5	35	55	1
Certificate of Death	Don No.			

	ı
Physician	l
/Medical	ļ
Examiner	
	П

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23a or 28a-f show early injury or other treumatic event, the Medical Exercise must be multiled at once.

Baltimore, Maryland 21215-0036

Medical Certification: To Be Completed by Physician/Medical Examiner

death certificate be executed	e attending physicien and Medium physicien and physicien and for use as the burial-transit	
To the Hospitel or Attending Physician: The law requires that the death certificate be executed	within 24 hours after death. To the Funerel Director: After this certificete has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	

Division of Vital Records, P.O. Box 68760,

	Decedent's Name (First, Middle, Last)						Date of Deat Month	h Day	Voor	3. Time of Death			
an . al	STEPHEN JEROME	FLORIAN					October		2005	11:00 P M			
er	4a. Facility Name (If not institution, give s.			4b. City, Town, or		of Death		4c. Coun	ty of Death				
	18864 Keedysville	Road		Keedysv	ille			Wash	ingto	on			
	5. Social Security Number 6. Sex	7. Age (In yrs. last birt		If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	9. Birthi	place (State or Foreign ntry)			
	138-56-2320	45	Yrs.				DEC. 27,			JERSEY			
	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	orloc	ration						10d. Inside City Limits			
'n			. 01 200	24(01)						1 ☐ Yes 2 🛣 No			
ecto	MARYLAND WASHINGT	ON			EEDYS	SVILL							
ă	10e. Street and Number			10f. Zip Code			11	Og. Citizen of		ntry?			
ral	5523 RED HILL ROAD				2175				.S.A.				
une		2. Was Decedent Ever in U.S. Armed Forces?	13. W	I. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					ace - Ameri ack, White,				
Ϋ́F	1 ☐ Never Married 2 ⚠ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No ff Yes, Give	1	☐ Yes 2½ No	Specify:			Spec	ify:	TTMD			
d b	15. Decedent's Educ	Year or Dates:	Doord	antia Llaval Casus	****			105 155-1-1		HITE			
lete	(Specify only highest grade		(Give k	ent's Usual Occupa and of work done of OO NOT use retired	lurina mos	t of workir	ng	16b. Kind of	Business/in	ndustry			
Be Completed by Funeral Director	Elementary/Secondary (0-12)	Colfege (1-4or 5+) 2.					7	ATTAT C	ADE C	OMD AND?			
ŏ	17. Father's Name (First, Middle, Last)		JWINE	CR & OPER		er's Name	(First, Middle, M			OMPANY			
B	RAYMOND JEROME FLO)RTAN				HIG			,				
70	19a. Informant's Name/Relationship (Typ		Mailing	g Address (Street a				City or Town	n State Zir	Codel			
	MICHELE D. FLORIAN												
	20a. Method of Disposition	20b. Place of	Dispos	RED HILL sition (Name of				Oc. Location					
	1 ⊠ Burial 2 □ Cremation 3 □ Re	entoval from State		atory or other plac									
	4 Donation 5 Other (Specify) 21. Signal the of Furiera / envice Livense			CEMETERY Name and Address	1	0/24	/2005 <u>1</u>	ŒEDYS	VILLE	, MARYLAND			
	21. Signature of Potential and Conference of Potential Signature of S	Paul M. Dean	BA	ST FUNER	AL HC	ME	7606 Old						
_	230 Book Falsetha diagonal Confession	U		a share and a of desire			Boonsbor		rylan				
	23a. Parti. Enter the disease, or complice shock, or heart failure. List only one	e cause on each line.	not ente							Approximate Interval Between Onset and Death			
	Immediate Cause (Final disease or condition	Compressind (in	by Vier	and	(fles	A lore	vica	-	Chock and Doam			
	Immediate Cause (Final disease or condition resulting in death) a. Compressional Captly Kee and Clast by civics Onset and Death Onset and Death												
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lne	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.	Due to (or as a consequence of	ot):										
Кап	that initiated events c.	Due to (or as a consequence of	-6).										
<u> </u>		Due to (or as a consequence of	וכ).										
dica	d.												
clan/Medical Examiner	IF FEMALE:												
lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death		Ectopic pregnancy					ate of deliver	ery Day Year			
	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 9☐ Unknown	5 🗌	Other (specify)					ionin	Day 16a1			
Completed by Physi			Ale	4.4			OO- Didas			h			
þ	Part II. Other significant conditions cont	ni puling to death but not resulting in	the un	derlying cause give	en in Parti.			_		he cause of death?			
ted							1 L Ye	s 2 □ No	3 Prot	pably 4 X Unknown			
ble							24a. Was an			ppsy findings available impletion of cause of			
Son							perform	ed? □ No	death?	2□ No			
Be (25. Was case referred to medical examiner?				26. Place	of Death	Check only one	1					
2	1 X Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ ER/Out	tpatient	3□ DOA Othe	ar: 4 □ Nu	rsing Hon	ne 5 🗆 Reside	nce 6 🖾 Ot	her (Specif	y) scene			
ü	27. Manner of Death 1 □Naturaf 5 □ Pending	28a. Date of Injury 28b. T	ime of	28c. Injury Work	at	2	8d. Describe ho		//	1.+			
atic	2 Accident investigation	Fred 1049los Facel	4	V Hours 100	res 2 🗌	No '	sugar p	mid l	y lam	min			
₽	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of fnjury - At home, far building, etc. (Specify)	m, stre	et, factory, office		2	8f. Location (Str.	eet and Num	ber or Rura	Poute Number,			
Cer		ME	fel				fort Ken	desid	1. 10	recity still			
ca	29a. Certifier 1 Certifying Physical Check only 2 Medical Examin	icien: To the best of my knowledge,	, death	occurred at the tim	e, date an	d place, a	nd due to the ca	use(s) and m	nanner as s	tated.			
Medical Certification: To	one) 2x Medical Examin	er: On the basis of examination and and manner stated.	wor inve	estigation, in my of	inion, dea	ui occurre	ou at the time, da	te and place	, and due to	uie cause(s)			
Σ	29b. Signature and title of certifier	. /		29c. License OCM			29	d. Date sign	ed (Month,	Day, Year)			
	Theoder 1	1 Keit mas					00	ctober	20	2005			
	30. Name and address of person who cor	npleted cause of death (Item 23a) (Type, P	Print) 111 Pe	nn St	reet				and 21201			
	THE WORE M. K	inf				~ ~~ 0		ا وتعدد	y 10	414 ZIZVI			

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Robert W. Ganz Sr. State of Maryland / Department of Health and Mental Hygieze 05 05-6986 35555 AKG Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Robert W. Ganz, Sr. October 14, 2005 12:44 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kent Narrows Bridge Chester Queen Anne's County 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. 1 X M 2 □ F Months Hours Yrs 85 Director 217-01-6140 Feb. 5, MD Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or iteme 23a or 28a-f ehov The Medical Examinar must be notified at MD Oueen Anne's Director Stevensville 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 420 Victoria Way 21666 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status e filed within 72 hours after du il Hygiene. other than "natural", or Item ☐Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Ship Builder Coast Guard other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental H int: if Item 27 is marked of John William Ganz May Elizabeth Walter 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: if Item 27 is eny injury or other tratence. Diana Ziegler/Daughter 849 Glen Court, Bethany Beach, DE 19930 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Oct. 18, 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State Metro Crematory Baltimore, MD 4 Donation 5 Other (Specify) 2005 21. Signature of Fyrieral Service Licensee P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DROW NING **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner and I-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): sician a P.O. Box 68760, Physician/Medical attending physical for use as the t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 Mo 3 Probably 4 □Unknown HEANT FAILURE CONGECTIVE 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? certificate 1 Yes Yes 2 No 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Mother (Specify) at SCENE ို 1 X Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 Pending investigation SUBJECT DROWNERD death. 10-13-05 19:30 PM 1 ☐ Yes 2 ☑ No 2 Accident I Director: d in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number. City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specily) within 24 hours after or To the Funaral Directompletely filled in by determined 4 Homicide Bony OF MISTER Kent Warnaus is RIDGE CHESTERMIN 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) O.C.M.E. October 15, 2005 bull alberte

State Registrar 31. Date filed (Month, Day, Year)

32. Re

1 8 2005

and address of person who completed cause of death (Hem 23a) (Type, Print)
Penn Street, Baltimore, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiere For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **14 Physician** 7:45 pM Donald Albert Gross October 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll 2150 Stone Road Westminster If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, July 04 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1936 1 □XM 2 □ F 69 MD 204-28-3209 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f ahnwary injury or other traumatic event, the Medical France. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 Yes 2 No Director Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21158 USA 2150 Stone Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1. Xes 2 No 1953 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married White If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Specify: á 1956 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Public Works Elementary/Secondary (0-12) College (1-4or 5+) Superintendent City of Westminster 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leslie Guy Gross Elsie Ruth Heffner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2150 Stone Road Westminster, MD Dorothy Gross/wife 21158 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Westminster Cemetery 10/18/2005 Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lisensee ²Pritts^Aftinefally Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. P. 11. Enter the effease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or han failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) APlastic **Physician** I REPUSTANCE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of). Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ģ Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pa 1 Yes 2 No robably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 21/2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 No 3□ DOA ٩ 1 Inpatient 2 ER/Outpatient 5 Residence 6 □Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Injury 1 Matural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deatl To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year) JL who completed cause of death (Item 23a) (Type, Print) 30. Name and ddr.ss

DHMH 17 Rev 1/2001

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State Registrar

Division of Vital Records, P.O. Box 68760,

2005

Destmiuster, MD 21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiere [] [] 5 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Gordon October 0 19, 2005 12:02 A M Charles Robert /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Southern Maryland Hospital Prince Georges Clinton If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 1 M 2 □ F Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Yrs. 52 1953 Washington DC Director 217-60-8848 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits r then "natural", or Items 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20603 4105 Bluebird Drive death 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Pueno Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) other then Painter/Wallpaperer Home Improvement 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill timent of Health and Mental H tant: If Item 27 is marked off jury or other traumatic even Jeanette Beaghan William Edward Gordon, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4105 Bluebird Drive, Waldorf, MD 20601 Gail Gordon - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If eny Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Huntt Crematory 10-20-05 Waldorf, MD of Funeral Service 22. Name and Address of Facility M00053 P. O. Box 156 Huntt Funeral Home Waldorf, MD 20604 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between fmmediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner attending physician and for use as the burial-trai Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 Probably 4 Laknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed certificete 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospitaf: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 2 2 ER/Outpatient 3 DOA this Director: After th 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Chatural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Pface of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide PCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours a

Baltimore, Maryland 21215-0036

State Registrar

2 0 2005

re and titte

29b. Signat

30. Name and address 9801

3

son who completed cause of death (Item 23a) (Type, Print)

Silves PRMMD 209-2

29c. License number

29d. Date signed (Month, Day, Year)

			For State Registrar	State of Ma		rtificate of I			Jiene () (leg. No.	15	35558	
	Physici	an	Decedent's Name (First, Middle,	-				Date of Dea Month	ith Day	Year	3. Time of Death	
	/Media		Marvin	Dawson		Hardesty		Octobe	r 14 20		2:10 p	
100	Examir	ier	4a. Facility Name (If not institution, s Anne Arundel Me		•		r Location of Death			y of Death		
					(In yrs. last birthday	Annapol If Under 1 Year	.1S If Under 24 Hrs.	8. Date of Birth	Anne			
3	Funeral Director		219-12-3976 Usual Residence of Decedent	1 X M 2□ F	79 Yrs.	Months Days	Hours Min.	(Month, Day Dec. 29	, Year)		place (State or Foreigntry) yland	
	yland yland		10a. State 10b. County		10c. City, Town or L	ocation				1	10d. Inside City Limit	
	Mar.	tor	MD Anne	Arundel	Edgewa	ter					1 Yes 2 N	
	th the	lrec	10e. Street and Number			10f. Zip Code		1	10g. Citizen of	What Cour	ntry?	
	238 238	ai	560 Mayo Road			21	037		τ	JSA		
1	72 hours after death with the Maryland "natural", or Itams 23e or 28e-f ehow idical Exprimental be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: 1		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ▼ No	lispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: White		
	72 ho natur	ted	15. Decedent's (Specify only highest	Education	16a. Dece	ident's Usual Occup	ation	10	16b. Kind of 8	Business/In	dustry	
	드 골	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) life.	DO NOT use retired	during most of working)	<i>'</i> 9				
ĺ	TI 700 = ***	Co	12		Owne	r				roleu	ım	
mai yiana	g g g S	Be	17. Father's Name (First, Middle, La	•			18. Mother's Name	(First, Middle,	Maiden Sumai	me)		
	s 1 and 2 should be f Health and Mental flem 27 is marked o other traumatic eve	P L	Marvin Dixon Har				Rose El					
	12 sho h and 7 is m traum		19a. Informant's Name/Relationship	•			and Number or Rura			, State, Zip	o Code)	
	s 1 and 2 f Health item 27 l	1	Betty M. Hardest	y (Wife)			, Edgewate		21037 20c. Location	- City or To	nun State	
	Page nent o ant: If ury or		1XX9urial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	cify)	Hillcres	osition (Name of matory or other place t Cemeter)	y 10/19,		Annapo			
3	permit. Departrimporte		21. Signature of Eugeral Service Li	eensee	2	2. Name and Addres Hardesty	Funeral H	Home, P.	.A.			
_	an and		23a. Part1. Enter the disease, or co	William Manager	badash Da astas		ly Avenue			D 214		
	Physician /Medical		shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a	gotne		Failm	e spiratory arr	est,		Approximate Interval Between Onset and Death	
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J		er	Sequentially list conditions,	b. Due to (or se s.	еспвадынген обу							
	uted 1 Insit	Examiner	Sequentially list conditions, if any, leading to initional actions cause. Enter Underlying Cause (Disease or injury that initiated events									
•	tificate be executed ig physician and as the burial-transit	Exa	resulting in death) Last	c Due to (or as a	consequence of):							
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	ath cer attendir for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	lecedent pregnant 2.5c. if yes, outcome or pregnancy 23d. Date of deliver past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) Month								
	luires that the de n signed by the a uld be detached i	þ	Part II. Other significant condition	s contributing to death but	not resulting in the u	underlying cause give	en in Part I.				he cause of death?	
100001	sw require s been sig	Completed						24a. Was a	ın 24b.	Were auto	psy findings available	
2	The tav	E						autops	med	death?		
		0	25. Was case referred to medical				26. Place of Death			1 🗆 Yes	2 L No	
	S S	0 8	examiner? 1 ☐ Yes 2 No	Hospital: Impatient	2 ER/Outpatie	nt 3 DOA Othe				ner (Specifi	iv)	
5	g Phy erthi eral d	ä	27. Manny of Death	28a. Date of Injury	28b. Time o			8d. Describe ho			9/	
5	Attending I r death. ector: Atter by the funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Day	Year) Injury		K? Yes 2 □ No					
	al or Attend after death Director: , d in by the f	Certification:	3 Suicide 6 Could no 4 Homicide determine		y · At home, farm, st (Specify)	reet, factory, office	2	8f. Location (St City or Town	treet and Numi n, State)	ber or Rura	l Route Number,	
	To the Hospitel or Atter within 24 hours after der To the Funeral Directo completely filled in by the	edical C	29a. Certifier (Check only one) Cartifying 2 Medical Ex	Physician: To the best of aminer: On the basis of e	xamination and/or in	th occurred at the time execution, in my op-	ne, date and place, a pinion, death occurre	nd due to the ca	ause(s) and malate and place,	anner as st and due to	tated. the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License	e number	2	9d. Date signe	d (Month,	Day, Year)	
		1) DO0	058291	7	16/	4/4		
			30. Name and address of person w	no completed cause of dea	ath (Item 23a) (Type			Α.	1	, 10	7	
			HOWERD YOU	& CMER	nue Av	med el V	nes.al	ante	Ann	200	is MD	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar						-		
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene [] [] 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Mabel Holland 10 19 2005 7:35 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 10609 Assateague Rd. Berlin Worcester If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min Days Months Hours 1 □ M 2 🖫 F Yrs. 2/10/1907 MD Director 98 219-36-7112 Usual Residence of Decedent with the Merylend 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ten 27 is marked other than "natural", or flems 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Worcester Berlin 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 10609 Assateaque Rd. Funeral USA Pages 1 end 2 should be filed within 72 hours efter deeth 2181112. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Specify: White δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If Item 27 is merked other than any injury or other traumatic event, the Magnes. Elementary/Secondary (0-12) College (1-4or 5+) 4 Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daniel Scott Rose Bassett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann H. Young 10601 Assateague Rd., Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State Evergreen Cemetery 10/22/05 Berlin, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Arvice Licensee 108 William St., Berlin, MD 28111 Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? ete hes l 1 Vos 2010 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 sesidence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA : After this c 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred s effer dea. 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours eff To the Funeral Di completely filled in edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Mont)

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Registrar's Signature 32. 2005

DHMH 16 Rev 6/95

			1 - For State Registrer	State of Ma	ıryland / Dej <i>Cı</i>	partment of I e <i>rtificate of</i>	Health and	Mental Hy	-)5 :	35560
			Registrer Decedent's Name (First, Middle, La	ist)			Death	2. Date of De	Reg. No.		3. Time of Death
П	Physici		James Ar	ndrew Ho	rrow d			Month	Day	Year	3:30 P M
	/Medic Examin		4a. Facility Name (If not institution, give		ward	4b. City, Town, o	or Location of Deat	Octobe		2005 nty of Death	
	Lamin		20112 Green Run C				hersburg				
	Funeral		5. Social Security Number 6. S	Sex 7. Age	(In yrs. last birthda	/) If Under 1 Year	If Under 24 Hrs	8. Date of Bi	dh	otgome 9. Birthp	Inne (Chate on Country
Ŀ	Director		213-48-0617	1 X M 2□F	54 Yrs.	Months Days	Hours Min.	Feb. 2	4,1951	Washi	ngton D.C.
	p ,		Usual Residence of Decedent 10a. State 10b. County		10- Ch. T						
	anyla shov	-		gomery	10c. City, Town or					1	0d. Inside City Limits 1 ☐ Yes 2 🛣 No
	he M	Director	10e. Street and Number	Somery	Ge	ithersbur	g				
	with 1	Ö	20112 Green Run	Court		10f. Zip Code	20879		10g. Citizen o	d Stat	•
	eath	Funerai	11. Marital Status	12. Was Decedent 8	ver in U.S. 13	Was Decedent of h		Coorify Voc or No		ace - Americ	
	fter d	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🕅 N		. Was Decedent of I If Yes, specify Cub	an, Mexican, Puer	to Rican, etc.)	B	lack, White,	
036	urs a	by	3 ☐ Widowed 4 X Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Spec	city:	White
21215-0036	72 hours after death with the Maryland naturel', or Itams 23a or 28a-f show dical Exercities must be notified at	Completed	15. Decedent's E	ducation	16a. Dec	edent's Usual Occup	ation	44	16b. Kind of	Business/Inc	dustry
21	thin 7	npie	(Specify only highest gri Elementary/Secondary (0-12)	College (1-4or 5	+) life	re kind of work done DO NOT use retire	d) -	-			
2	ed wi	Co		4	Cont	ractor Ad					tractor
pu	be fill d otf	Be	17. Father's Name (First, Middle, Last Thomas F. Howa					me (First, Middle		ame)	
Z	ould Men varka	²						ia Hasti			
Maryland	12 sh and is m		19a. Informant's Name/Relationship (Matthew T. Howard			ling Address (Street					
e)	1 and 1ealth 1m 27 1her t		20a. Method of Disposition	Son	2202 20b. Place of Dis	Mohegan .	Drive Ap	t Al, Fa	11s Chu	ırch ,	VA 22043
Baltimore,	nt of J		1 ☐ Burial 2 X Cremation 3 ☐		Metropo	ematory or other pla	Octo	2685 ¹⁸	20c. Location		
ij	it. Partmer rtant rtant njury		* 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice	11	tr	ematory					Virginia
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "neturet", or items 23a or 28a-f show any hipty or other traumatic evant, the Medical Examiner must be notified at once.		TRACE	tue)		22. Name and Addre Deer Park	Drive, (Devol F Gaithers	uneral burg, M	Home, D 208	10 East 77
П			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do not e	nter the mode of dyi	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):						
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	led Isit	nine	cause. Enter Underlying Cause (Disease or injury	· ·	ibetes Me]	litue					
ıb.	xecu and al-trar	xan	that initiated events resulting in death) Last	C.	consequence of);	TICUS					
68760,	ificate be executed g physician and as the burial-transit	edicai Examiner		Smc	king						
687	tificate ig phys as the	edic		0.							
Вох			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d. D	ate of delive	ry
	0 0 0	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at 1		□Ectopic pregnancy □ Other (specify) _					Day Year
0.	tt the by th tache	hys	9 Unknown	9□ Unknown							
S, P	The taw requires that the de ate has been signed by the a page 2 should be detached	by Physician/M	Part II. Other significant conditions	contributing to death bu	t not resulting in the	underlying cause giv	en in Part I.	23e. Did t	obacco use co	ntribute to th	e cause of death?
ord	en si	pel						1 💢 '	Yes 2 ☐ No	3 🔲 Prob	ably 4 Unknown
ecc	law r as be	Completed						24a. Was			osy findings available inpletion of cause of
<u> </u>	The ate h page	Corr						perfo	rmed? 2 X No	death? 1 ☐ Yes	
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n c	ing F	ion:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injury	Wor		28d. Describe I	now injury occu	irred	
isi	death death stor:	icat	2 Accident investigatio 3 Suicide 6 Could not b		- At home form		Yes 2 □No	COS Lanation (Channel and Alum	has as Division	(Davida Maria
Division of Vital Record	after Direction by	Certification:	4 Homicide determined	building, etc.	ry - At home, farm, s (Specify)	treet, factory, office		City or Tox	vn, State)	iber or Hurai	Route Number,
	spita lours neral		29a. Certifier 1 X Certifying Ph	ysicien: To the best o	f my knowledge, dea	th occurred at the tir	ne, date and place	and due to the	cause(s) and m	nanner as sta	ated.
	To the Hospital or Attending Physician: The law within Z Lands attended. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medicai	(Check only 2 Medicel Examone)	niner: On the basis of and manner stat	examination and/or i	nvestigation, in my o	pinion, death occu	rred at the time,	date and place	, and due to	the cause(s)
	To the Comp	Ĭ	29b. Signature and title of cepifier	RAM		29c. Licens	e number		29d. Date sign		
)				1 000		D	1936		Octobe	r 18,	2005
	5		30. Name and address of person who								
	-		Sally Belcher M	1.D., 9715			ve Suite	501, Ro	ckville	, MD	20850
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 0 20	1.00	r's Signature	we					
			001 20 20	A COMPANY	No lake						

		1 - State Ragistrar			Cer	tificate of L	Death		Rag.	No.		
S-10-	3	1. Decedent's Name (First, Midd	le, Last)			-			te of Death		3. Time of De	ath
Physici		Jerry	Miltor	1	Hawki	ng				Day Ye. 12, 200		n ^M
/Medic Examin	State II	4a. Facility Name (If not institutio			IIQ WIKI	4b. City, Town, or	Location of D		CODE	4c. County of D		<u> </u>
LAGITI		Calvert Memori	al Wognital			Prince	Exada	rick		Calve	vet	
Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. la	st birthday)	If Under 1 Year	If Under 24	Hrs. 8. Da	te of Birth		Birthplace (State or Fo Country)	oreign
Director		214-30-0154	1 ∑ M 2□ F	71	Yrs.	Months Days	Hours	Min. (Maxz	onth, Day, Ye	934 V	Country) irginia	
A - 4		Usual Residence of Decedent						1.u.y	21,1)J4 V	rrginia	
yland		10a. State 10b. County	1	10c. City.	Town or Loc	ation					10d. Inside City L	_imits
Mar.	to	MD Calve	ert			Owings					1 ☐ Yes 2	₹No
1 the	Director	10e. Street and Number				10f. Zip Code			10g.	Citizen of What	Country?	
death with the Maryland ma 23a or 28a-f ehow rmat be notfiled at		8521 Solomons	Teland Road	4		207	36			USA		
ha 2	Funeral	11. Marital Status	12. Was Decede	nt Ever in U.S	i. 13. W	as Decedent of Hi		? (Specify Ye	es or No-	7	merican Indian,	
tter of	Fun	1 ☐ Never Married 2 ☑ Mar	Armed Force ned 1		If	Yes, specify Cuba	n, Mexican, P	Puerto Rican,	etc.)	Black, W	/hite, etc.	
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J with	Eo	11	College (1-4)		owner	electric	motor	repai	r shop	elect	ric motor	
Hygin other	Bec	17. Father's Name (First, Middle,	Last)				18. Mother's	Name (First,	Middle, Mai	den Sumame)		
ld be ental ked c	To B	Alvin Milton	Hawkins				Lucy	Vict	oria	Hudson	1	
as y called K. 1.2. 2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Ma	-	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailing	Address (Street a		or Rural Rout	e Number, Ci	ty or Town, Stat	e, Zip Code)	
and 2 leath a leath a rm 27 le		Barbara A. Haw	kins wife		8521	Solomons	Tslan	nd Road	- Owir	nas MD	20736	
is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. If Health and Mental Hygiene a few second seco		20a. Method of Disposition	MIND, WILL	20b. Pla		ition (Name of atory or other place		Date	-	Location - City		
ages ont of		1 ⊠ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		110			1	10 00	.O.F. D			
Deficiency Definite Pages Department of Important: If it Iny injury or o		21. Signature of Funeral Service		FT.	1	ln Cemet	-	1-18-20	105 Br	rentwood	I, MD	_
permit. Pages 1 Department of He Important: If iter any injury or oth		1100000	> 6m-								20726	
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		shock, or heart failure. List	t only one cause on each	h line.				ruiac or respi	latory arrest,		Interval Betwee	
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certificate be executed ording physician and use as the burial-transit	v/Medical		d								1	
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atten for us	_	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal o	death 3 □I	Ectopic pregnancy				23d. Date of Month	delivery Day Yea	ıΓ
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w requires that the death w requires that the death been signed by the atter should be detached for u	Physicia	Part II. Other significant conditi	One contributing to deat	h but not recul	ting in the un	dorlving ocuso cure	n in Bort I	25	Re Did tobace	O usa contribute	to the cause of deat	
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law requires las been signed 2 should be	ted	STROKE	1					_	1 tes	2 NO 3	Probably 4 Onk	nown
as b	ple	NYPERTENS	SIDN					24	a. Was an autopsy	24b. Were	autopsy findings ava to completion of caus	ilable e of
The The ate h	Completed by							1	performed Yes 2	? death	? ′es 2□ No	• • •
Physician: The lave this certificate has al director, page 2.3	Be (25. Was case referred to medica examiner?	ı				26. Place of	Death (Chec	ck only one)			
ysic als ce dire	2	1 ☐ Yes 2 € No	Hospital: 1 1 Inp.	atient 2 E	R/Outpatient	_3□ DOA Othe	er: 4 🗆 Nursır	ng Home 5	Residence	6 □Other (S	pecify)	
or Attending Phy after death. Director: After this in by the funeral of		27. Manner of Death	28a. Date of I	njury Day Year)	28b. Time of Injury	28c. Injury Work	at	28d. De	escribe how in	njury occurred		
ath. Be fur	atic	1 Natural 5 ☐ Pendii 2 ☐ Accident investi	igation		,,		res 2 □ No					
Atte	iffe	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 286. Place of	Injury - At hon etc. (Specify)	ne, farm, stre	et, factory, office		28f. Lo	cation (Street	and Number or	Rural Route Number	·.
To the Hospitel or Attending Physician: The law requires that the death within 24 hours after death. The Funeral Director: The this certificate has been signed by the attent completely filled in by the funeral director, page 2 should be detached for a	Certification:		ballding.	oto. (Specify)				0,1	y 01 1 0 m11, 31	410)		
ospit hour ineral	al	29a. Certifier 1 Certifyii (Check only 2 Medical	ng Physician: To the be	st of my know	ledge, death	occurred at the tim	e, date and p	lace, and du	e to the cause	e(s) and manner	as stated.	
n 24 he Fi	edical	one)	Examiner: On the basis and manner	s of examination stated.	on and/or inve	estigation, in my op	oinion, death o	occurred at tr	ie time, date	and place, and c	lue to the cause(s)	
To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	×	29b. Signature and title of certifie	ər			29c. License	number		29d.	Date signed (Mo	onth, Day, Year)	
		Ptu.	m			D40	0370)	1	0/13/0	5	
٠, ٠,		30. Name and address of person	who completed cause of	of death (Item :	23a) (Type, P					, , .		
15+1		Peter Wisniesk					310, P	r. Fre	derick	, MD 20	678	
Sta	te	31. Date filed (Month, Day, Year,) 32. Reg	istrat's Signatu	re		-					
Registr		OCT	1 4 2005	Blown	· K	Sperke						
DHMH 17 Rev 1/2	001											-

State of Maryland / Department of Health and Mental Hygiene 15

1 - For State Registrar Certificate of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 8:30 A M 12, October 2005 Neva Marie Harman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert County Prince Frederick Calvert Memorial Hospital If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Oct. 30, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Funeral 1 □ M 2 🗓 F West Virginia 80 Director 233-68-1326 Oct. Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10h Counts Item 27 is marked other than "natural", or items 23s or 28e-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No MD Calvert County Solomons Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20688 11450 Asbury Circle Apt.#205 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 💆 No Specify: White Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) f Health and Mental Hygiene. Item 27 is marked other than College (1-4or 5+) Elementary/Secondary (0-12) Retail Sales Department Store permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: if Item 27 is marked oths any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ဥ Jane E. Dahmer Jasper D. Riggleman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Linda Noel (Daughter) 351 Sheckells Road, Huntingtown, Maryland 20639 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition October 19. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ⁴ 4 □ Donation 5 □ Other (Specify) Maryland Vets. Cemetery 2005 Owings Mills, Maryland 21. Signature of Fundal Service Liganses 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Michael W. Lee 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ongestive months **Physician** /Medical Due to (or as consequence of): Examiner Restrictive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physiclan/Medical Examiner teute (Oronum and burial-tran Due to (or as a consequence of): physician 0000000 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 ☐ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? Hypertensio page 2 autopsy performed 1 ☐ Yes 2 ♠ No Obstructive 2 No certificate hronic director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Unpatient Medical Certification; To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Sitt After the funeral of 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after death To the Funerel Director:. completely filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 0 Hospitel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number title of certifier 29b. Signature and 060390 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRINCE FREDERICK, MD ADEEB) ABER 100 HOSPITAL 31. Date filed (Month, Day, Year) 32. Registra s Signature State

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760,

of Vital Records,

4 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiena 15 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 15 2005 5:30 PM October Harry Ellsworth Hager, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Count Hagerstown 17342 Cindy Lane If Under 1 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 ☑ M 2 □ F 65 Director 5 1940 219-36-3012 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itams 23a or 28a-f show the Medical Examinat must be notified at 1 ☐ Yes 2 No Hagerstown Director Maryland Washington 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21740 17342 Cindy Lane United States death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. within 72 hours aftar 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should ba filed withinent of Health and Mental Hygiene.
Int: if itam 27 is markad othar ther Truck Mfq. Machinist 7 is marked other traumatic avant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stanley R. Hager Beulah M. Rudisell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sylvia R. Hager (wife) 17342 Cindy Lane Hagerstown Maryland 21740 itam 27 othar to 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Smithsburg Crematory 10-17-05 Smithsburg Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Douglas A. Fiery Funeral Home 1331 Fastern Blvd. N. Hagerstown Maryland 21742 Daucier 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or left failure. List only one is use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 3 months disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sign. Completed by 1 Tyes 2 → No 3 □ Probably 4 □ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy perform certificate 1 ☐ Yes 2 ☐ No 1 🗌 Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home sidence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA (his funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After or Attanding 1 Natural 5 Pending investigation death. 2 Accident 1 Yes 2 No within 24 hours after deat To the Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide Sertifying Physician: i o the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Cenmer (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print) filed (Month, Day, Year) 32. Degistrar's Signature State 20 2005

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiefe 15 1 - State Registral Certificate of Death 2 Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** October 4:106 Esther Sangster Harlow 2005 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Doctors Community Hospital Lanham If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2**X** F 76 578-34-1962 Yrs. 12/21/1928 Washington, DC Director Usual Residence of Decedent 10a State 10b. County 10c, City, Town or Location 10d, Inside City Limits ir than "natural", or Itema 23a or 28a-f show the Medical Examitive coust be notified at 1 X Yes 2 No Director Maryland Prince Georges Greenbelt 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8677 Greenbelt Road #202 20770 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 X Divorced Completed 16a Decedent's Usual Occupation 16b Kind of Business/Industry 15 Decedent's Education permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiens. Important: If item 27 is marked other than "ne any triury or other traumatic event, the Madia. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) G.P.O Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Fenwick Ward Beecher Ada Dunford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wendy R. Hatcher/ Niece 6515 100th Avenue Seabrook, MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/19/2005 Suitland, MD Cedar Hill Cemetery 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) CIPRHOSIS /Medical Due to (or as a consequence of): Examiner ANOTITES PSIN yerne ALPHA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner certificate be executed burial-transit been signed by the attending physician and should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No OSTEDARTHRITIS تنحاز HY ROTEN SION FAIL 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death | Check only one Hospital: 1 Inpatient Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Hospitel or Attending Pt 24 hours after death. Funeral Director: After th 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funeral C
completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year, D55554 10/15/2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TERINSOND SIE # SA STOPHON THOMAS MITSURAL MID. 7525 412020 31. Date filed (Month, Day, Year) 0CT 18 2005 State Registrar

For State Registrar	State of Ma		partment of F ertificate of			ДФ) () 5 . No.	355	66
Decedent's Name (First, Midd Helen N. Hol					2. Date of Death Month	1 7	Year 41	of Death
ROLLING OF MAN	n, give street and number) Nincton Nedic	ol Conto	4b. City, Town, o	r Location of Death		4c. County or Anne	Death Aviade	1
Social Security Number 218–14–6730		(In yrs. last birthda 80 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y		9. Birthpface (State Country)	or Foreigi D
sual Residence of Decedent	1							
MD 10b. County Ann	e Arundel	10c. City, Town or	Location Arnold				10d. Inside	City Limits s 2 X No
De. Street and Number	D 3		10f. Zip Code		100	, Citizen of Wh	-	
642 Shore Acr	es Road			21012		1	USA	
Marital Status Never Married 2 Mar		ver in U.S. 13	3. Was Decedent of H		ecify Yes or No- Rican, etc.)	Black	- American Indian, White, etc.	
3 X Widowed 4 ☐ Divorce	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify:	White	
15. Deceder (Specify only higher Elementary/Secondary (0-12)	nt's Education est grade completed) College (1-4or 5-	(Gi	cedent's Usuaf Occup ve kind of work done b. DO NOT use retire	durina most of work	ting 16	ib. Kind of Bus	iness/Industry	
12	College (1-401 54	Ph	narmacist	Technicia	n	Drug 1	Fair	
7. Father's Name (First, Middle					e (First, Middle, Ma	iden Sumame)	
Unavailab					ailable			
9a, Informant's Name/Relation			illing Address (Street					
Patricia L. T. Da. Method of Disposition 1 ↑ Burial 2 □ Cremation ↑ 4 □ Donation 5 □ Other (3 □Removal from State	20b. Place of Dis	2 Shore A position (Name of rematory or other planers Ceme	oct	Date 20	c. Location - C	1012 City or Town, State	
1. Signature of Funeral Service	EH/len		22. Name and Addre Barranco 495 Gov.	& Sons, P Ritchie H	wy, Sever	na Parl	k, MD 21	146
23a. Part1. Enter the disease, o shock, or heart failure. Lis mmediate Cause (Final disease or condition esulting in death)	r complications that caused to only one cause on each line a.	he death. Do not e).) CGAN	Failure	such as cardiac	or respiratory arres	t,	Approximation finterval Be Onset and	etween
Sequentially list conditions, any, leading to immediate	b. Gam Due to (or as a	consequence of):	tive :	sepsis			Hou	3
any, leading to immediate ause. Enter Underlying cause (Disease or injury hat initiated events esulting in death) Last	1. Prev	monuc consequence of):	2				Day	5
FEMALE:	d	f pregnancy	3 □Ectopic pregnanc			23d. Date	of delivery	

Physician /Medical **Examiner**

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Be Completed by Funeral Director

2

Completed by Physician/Medical Examiner

Medical Certification; To Be

27.

29a.

Funeral

Director

25. Was case referred to medical examiner?

4 Homicide

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 € No	23c. If yes, o 1 ☐ Live 4 ☐ Pre

1		itribute to the cau 3 Probably	

24a. Was an autopsy performed: 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No

		26. Place of Death (Check only one)											
lc	spital:	1 XInpatient	2 🗆	ER/Outpatient	3 🗆 [AOC	Other:	4 Nursing H	lome	5 Residence	6 ☐ Other (Specify)		
	28a. C	ate of Injury Month, Day Ye	ar)	28b. Time of Injury		28c.	Injury at Work?		28d.	Describe how inj	ury occurred		

1 ☐ Yes 2 N	0	Hospital:	Inpatient	2□ER	/Outpa
Manner of Death Natural	5 Pending investigation	28a. D	ate of Injury Month, Day Ye	28 ear)	b. Tim Inju
2 Accident 3 Suicide	6 Could not be		face of Injury	- At home	farm

М

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifier (Check only one)	1 Certifying Physicien: To the best of my knowled 2 Medicel Examiner: On the basis of examination and manner stated.

determined

dge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature a	and title of certifie	
	Maria	Auis

29c. License number

29d. Date signed (Month, Dey, Year)

21061

(no) completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

MARY A GAVIRIA
31. Date filed (Month, Day, Year) 32. Resistrar's Signature

1 8 2005



State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05 1 - For State Registrar Certificate of Death Rag. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 17 2005° OCTOBER 12.34P M HARPER KYONG S 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) MONTGOMERY SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Month, Days | Hours | Min. | MARCH 20 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 10 M 20 F KOREA 62 230 86 3448 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County 1√ Yes 2 No GERMANTOWN MONTGOMERY 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20876 11828 EATON MANOR DR. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married ASIAN 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE HOUSEWIFE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last, YON YANG CHON SON YUN CHANG 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11828 EATON MANOR DR. GERMANTOWN MD 2087619a. Informant's Name/Relationship (Type, Print) WILLIE HARPER / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place)
NORBECK MEMORIAL PARK 20c. Location - City or Town, State Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/21/05 OLNEY 4 □ Donation 5 □ Other (Specify) 22. Mains and Address of Facility CHARLES HINDS FUNERAL SERVICE Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 12303 KAYAK DR UPPER MARLBORO MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final Myocardia disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, ii any, reading to infriediate cause. Enter Underlying Cause (Disease or injury Due to (or as a sonsaquence of) resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death Month Day Year 5 Other (specify) 4 Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably Anknown 24a. Was an

Physician /Medical Examiner

permit. Pages 1
Department of H
Important: If Ite
any injury or ot
pace.

Physician

/Medical

Examiner

MD

Funeral

Director

ahow

ne 23a or 28a-f ahov must be notified at

, or Itame 2

Pages 1 and 2 should be filled within 72 hours after of nent of Heelth and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or Item ury or other traumatic avent, the Medical Examinat

Baltimore, Maryland 21215-0036

Funeral Director

Completed by

death with the Maryland

Examiner Physician/Medical þ Completed

Certification: To

Medical

sicien and burial-transit ed by the attending physicien detached for use as the buria cate has been sign. death. ofter deatl Diractor: filled in by

Division of Vital Records, P.O. Box 68760.

the Hospital or Attending Physician:

To the Hospital within 24 hours el To the Funeral D completely filled i

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ 1/0 9 Unknown

25. Was case referred to medical examiner?

27. Manner of Death

Natural

2 Accident

4 Homicide

3 Suicide

29a. Certifier

1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

26. Place of Death Check only one

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 R/Outpatient 3 DOA

Hospital: 1 | Inpatient 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier

29c. License number D0057455 29d. Date signed (Month, Day, Year) October 17, 2005

30. Name and address of person who completed cause of death (flem 23a) (Type, Print) ROCKVILLE MD 20850 S. SAXENA MD

and manner stated

State Registrar 31. Date filed (Month, Day, Year)

5 Pending investigation

6 Could not be determined



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35568 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Joseph Edward Harrison Physician October 17, 2005 10:45 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Southern Maryland Hospital Clinton 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 10/31/24 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Year) 1 X M 2 □ F Days 80 Yrs Director 578-22-1529 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28e-f ehow r than "natural", or Itams 23a or 28e-f ehov the Medical Examinar must be notified at 1 Yes 2 No Completed by Funeral Director P.G. Bowie Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16010 Excalibur Rd. # A-203 20716 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Depertment of Health and Mental Hygien important: If Item 27 is marked other the eny Injury or other treumatic event, the once. 12th Taxi Cab Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Beatrice Dudley Joseph Harrison ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonita H. Marshall/Daughter 16010 Excalibur Rd. #A203, Bowie, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 10/22/05 Landover, Md. Harmony Mem. Park 21. Signature of Funeral Service Licensee 22 H. S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 any rate 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Myocarch Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, seating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Completed by Physician/Medical Examine anding physician and use as the buriat-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Mumo wi a 2 ₽No 3 Probably 4 ☐Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No certificate Division of Vital 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one 1 ☐ Yes 2 ☑ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Inpatient 2 ER/Outpatient 3 DOA I Director: After this d in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Could not be determined 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours e To the Funeral C completely filled Certifying Physician: To the best of my knowledge, death construct at the time, data and plane, and due to the nause(s) and transport as stated. Medical 29a. Certifier Certifyin Physician: To the best of my knowledge, death denured at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29c. License number 29b. Signature and title 29d. Date signed (Month, Day, Year) Ochber 17 D0055120 of person who completed cause of death (Item 23a) (Type, Print) 1328 Sonthern Avenue SE Soute 310 Washington DC 20032 31. Date filed (Month, Day, Year) 2. Registrar's Signature State OCT 2 0 2005 lieu & Spark Registrar DHMH 17 Rev 1/2001

		1	For State Registrar	State of Maryland		artment of H		nd Mental I	Hygier Reg. N	. U U U	3:	5569
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	Physicia		Mary C. Hilgart	ner				Oct.		200	5 1	2:45 PM
	/Medic Examin	Mary 1	4a. Facility Name (If not institution, give s	reet and number)		4b. City, Town, or	Location of	Death	4	4c. County of	Death	
	Examin	G1	Upper Chesapeake N		r	Bel A	ir			Harfo		
103	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 2 Hours	Min. 8. Date of	Birth Day, Yea	ar) S	Birthplace Country)	(State or Foreign
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	ith the Marylan or 28a-f ahow	Director	10e. Street and Number	_		10f. Zip Code				Citizen of Wh	at Country :	
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	r dea	by Funeral	TT. Wantar Clares	Was Decedent Ever in U.S Armed Forces?	5. 13.	Was Decedent of H If Yes, specify Cuba	iispanic Orig an, Mexican	Puerto Rican, etc.	.)		White, etc.	indian,
<u>_</u> 98	or It	Y.	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:			Specify:	Whi	te
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ano	ntal ed o	Be C	Harry J. Gambl	e			Ma	rgaret 1	E. L	andgr	af	
Ξ	houk d Me mark matic	L L	19a. Informant's Name/Relationship (Type		19b. Mail	ing Address (Street	and Numbe	r or Rural Route N	umber, Cit	y or Town, S	itate, Zip Co	de)
Maryland 21215-0036	d 2 s th an th an treu		James H. Hilgart		715	Maplehu	ırst	Lane, M	onkt	on, M	4D 21	111
	Teal Heal		20a. Method of Disposition	20b. Pl	lace of Disp	osition (Name of	ca) C	oct. 28,	20c	Location - C	-	
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` <u>=</u>	it. P. rande ritand		21. Signature of Funeral Service License		oria	2. Name and Addre	ss of Facilit		rtens	tein	Mortu	ary, Inc.
Ba	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The marked other than "natural", or Itams 23a or 28a-f ahov any injury or other treumatic avant, the Madical Examinar must be invitited at once.		mala I al	Manane		24 Second						
3			23a. Part1. Enter the disease, or compl	cations that caused the death						-	l Ac	oproximate terval Between
			shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	_	0.0						nset and Death
	Physician /Medical	ł i	disease or condition resulting in death)	Respirale	my	four	ve					
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	leath certificat attending phy	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna						23d. Date	of delivery	
Box	atter for u	ciar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d		□Ectopic pregnanc□ Other (specify)				Mont	ith Da	ay Year
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	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit		Part II. Other significant conditions co	ntributing to death but not res	ulting in the	underlying cause gr	ven in Part I	. 23e.	Did tobac	co use contril	bute to the	cause of death?
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<u>خ</u> ک	after Dir	Certification:	4 Homicide	building, etc. (Specif	(Y)			City	J. 70#11, C			
-	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 1 Certifying Phy	rsician: To the best of my kno	owledge, de	ath occurred at the t	time, date ai	nd place, and due t	o the caus	se(s) and mar	nner as stat	ed.
	• Ho 124 t • Ful letely	Medicai	(Check only 2 Medical Exam	iner: On the basis of examina and manner stated.	ation and/or	investigation, in my	opinion, dea	ath occurred at the	ume, date	anu piace, a	TIO QUE TO T	10 vause(s)
_	To th withir To th	M	29b. Signature and title of certifier			29c. Licer	nse number		29d	Date signed	(Month, De	ey, Year)
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	~ 5		30. Name and address of person who d	ompleted cause of death (Iter	n 23a) (Typ	e, Print)		11			6	11
	M		Fond Xian	e, Upper	Che	Sapier	le)	Wednes	(enliz	- BE	Hir
		tate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	1 0						mD
	Regis	trar	NYO 1 1 9 7	005	All .	Traces 8						

State of Maryland / Department of Health and Mental Hygiers Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 1:30 A M October 20 2005 Florence Flowers Johnson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 2607 Old House Point Road Fishing Creek Dorchester If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 1 M 201F Dec. 18, 1913 91 Maryland Director 213-12-5164 Usual Residence of Decedent 10d Inside City Limits 10c, City, Town or Location 10a, State 10h County or Items 23a or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Dorchester Fishing Creek Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2607 Old House Point Road 21634 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. ☐Yes 2XNo 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white Baltimore, Maryland 21215-0036 þ 3 Widowed 4 □ Divorced Year or Dates: "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) other than College (1-4or 5+) Elementary/Secondary (0-12) own home homemaker 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be 1.
Department of Heelth and Mental L
importent: if litem 27 is mr
any injury or othonce. 2 should be fi and Mental H Is marked of Elba Flowers Daniel Tall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2607 Old House Point Rd., Fishing Creek, MD 21634 John M. Johnson son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State Hosier Mem. Churchyard 10/23/05 Fishing Creek, MD ^ 4 □ Donation 5 □ Other (Specify) Thomas Funeral Home P.A. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Systo Contestive Immediate Cause (Final 100 UNCTION **Physician** resulting in death) /Medical Due lo (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ģ 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 2 340 1 ☐ Yes 2 ☐ No 1□ Yes certificate the Hospital or Attending Physicien: 26. Place of Death Check onli one director 25. Was case referred to medical Be examiner Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 70 1 Yes 2 No After thi 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Ś 4 T Homicide hours efter within 24 hours e To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Gertifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c License number 29b. Signature and title of certifier To 10/21 100061 822 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Byrn St. Cambridge 503 Widmais M. D. Eric 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiepe 15 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Victoria Peyser Jacobson October 11, 3:00 P M 2005 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Brighton Gardens N. Bethesda Montgomery if Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 91 217-44-3901 1914 Wash. D. C. Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1∏Yes 2□No Maryland Montgomery N. Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 5550 Tuckerman Lane, # 217 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 No If Yes, Give 1 ☐ Yes 2 X No Specify: White 3 ☑ Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Col. Julius I. Peyser Miriam Prince 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol J. Luskin - Daughter 8700 Rayburn Road, Bethesda, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Judean Mem. Gardens `4 ☐Donation 5 ☐ Other (Specify) 10/14/2005 Olney, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Edward Sagel Funeral Direction, Inc.
1091 Rockville Pike, Rockville, Maryland 20052 Donald (23a. Part1. Enter the disease, or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Congestive Heart Failure Due to (or as a consequence of): Valular and Coronary Heart Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ UnknownX 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2**X** No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Marsing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 21 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D1995 MIS 2300 IND

The law requires that the death certificate be executed nding physician and use as the burial-tran use as the ō as been signed by the 2 should be detached o. Division of Vital Records, P. has page certificate this : After thi or Attending To the Hospitel or Attending within 24 hours after death.
To the Funerel Director: Aft

Physician

/Medical

Examiner

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Funeral Director

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Certification:

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

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Department of I
Important: If its
any injury or o

Physician /Medical

Examiner

State Registrar

31. Date filed (Month, Day, Year) 20

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Dr. Ace Lipson, M. D. 1120 19th Street, N.W., Suite 200, Washington, D. C.

20036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiore 10 5

		For State Registrar 1. Decedent's Name (First, Middle, Last)			Certific	ate of L	Death	2. Date of Deat	eg. No.		0 T 1/D	
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LAdminer		Casey House				Rockvi	11e	Montgomery				
Funeral		5. Social Security Number 6. Sex		(In yrs. last bir	Mont	der 1 Year hs Days	If Under 24 Hrs Hours Min.	8. Date of Birth			ace (State or Foreig Columbia	
Director		3.0 01 2720	M 2□F	68	Yrs.	Days	Tiodis iviii.	Jan. 30	, 1937	South	Columbia 1 America	
and *	Usual Residence of Decedent									d. Inside City Limits		
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288-	9	10e. Street and Number		Deche		Zip Code		1	0g. Citizen of W	Citizen of What Country?		
3a or		6004 Rossmore Driv	re		20814				. A.			
is 1 and 2 should be filed within 72 hours after death with the Maryland of Heelih and Mental Hygiene. Item 27 ie marked other then "naturel", or items 23a or 28a-f show other traumatic event, the Medical Exprirer must be invitilled at the completed by Funeral Director.	ਨ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	1 □Yes 2 No			Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) XX Yes 2□ No Specify:				- America , White, e		
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hould Men marke matic	۵	19a. Informant's Name/Relationship (Ty		19h	Mailing Addr	ess /Street a		ıral Route Number		State Zin (Codel	
ith an		Estela M. Jimenez						Bethesda,				
THE	t	20a. Method of Disposition			f Disposition (20c. Location - C			
rmit. Pages 1 pertment of H portant: if ite y injury or ot		1 ☐ Burial 2 🛣 Cremation 3 🛣 R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Metro	polita Cremat	n	ŀ	13/2005	4.1		W	
permit. Depertm Imports eny inju		21. Signature of Funeral Service Liepnse	Dom	es	22. Name Edwa 1091	and Addres	s of Facility gel Fune:	ral Direc ke, Rocky	tion, I	nc. arvla	and 2085	
	1	23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused	the death. Do	not enter the r	node of dying	, such as cardia	or respiratory arre	est,		Approximate	
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Non Smal	1 Ce11	Lung C			c to Spin		1 1	Interval Between Onset and Death	
Examiner			Due to (or as a	consequence	of):							
in sit	luer.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Соповушенся	uf).							
tificate be executed g physicien and as the burial-transit	EX A	that initiated events resulting in death) Last	Due to (or as a consequence of):								·	
	Medic	IF FEMALE:	3c. If yes, outcome of	of pregnancy							E FEETS	
requires that the death certified is signed by the attending hould be deteched for use a hould be deteched for use a sted by Physician/Me	nysician	23b. Was decedent pregnant in the past 12-months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown							23d. Date of delivery Month Day Year			
ä 5 5 <u>0</u>	2	Part II. Other significant conditions cor Malignant & Spin									cause of death?	
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ician certifi ector	0	25. Was case referred to medical examiner?	locoital:			Otho		ath Check only on				
Physician: this certific ral director, To Be (1 Yes 2 No 27. Manner of Death					4 Industry	Home 5 Residence 6 Other (Specify) Hospic				
ding After funer		1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	njury M	28c. Injury Work		28d. Describe no					
To the Hospital or Attending Physical Mithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral diffication: To Medical Certification: To	erillica	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office 28f. Loc					28f. Location (St. City or Town	Location (Street and Number or Rural Route Number, City or Town, State)			
• Hospita 24 hours • Funeral letely fille	O Can	29a. Certifier Check only one) 2 Medical Examin	nician: To the best of ner: On the basis of and manner stat	examination an	death sonund/or investigat	ed at the timi ion, in my op	e, date and place inion, death occu	t, and due to the ca cred at the time, da	use(s) and man ite and place, ar	ner as star nd due to t	he cause(s)	
within To the compli	<u> </u>	29b. Signature and title of Brutter				29c. License	number	25	d. Date signed	(Month, D.	ay, Year)	
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	6						1		/	1 / 1		
1>		30. Name and address of person who co	mpleted cause of de	ath (Item 23a)	(Type, Print)						0	
1>		30. Name and address of person who co Dr. Charles Harr 31. Date filed (Month, Day, Year)	ison 6001			11 Roa	d, Rocky	ville, Ma	ryland 2	20855	0 200	

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	Physici /Medio Examin	al	Decedent's Name (First, Middle,	m. 20		201	4b. City,	Town, or	Location ol	OCA	te of Death onth	Day Year	2 1815bw
	Examili	ei	Shady Grove Adv					ckvi.				Montgo	
	Funeral Director		5. Social Security Number 225-60-0371 Usual Residence of Decedent	5. Sex 7. A(1.1≦ M 2 ☐ F	ge (In yrs. Ia	est birthday) Yrs.	If Unde Months	r 1 Year Days	If Under 2 Hours	Min. (Mo	te of Birth onth, Day, Ye	9. Bi 1945 Vi	rthplace (State or Foreign country) rginia
	4 within 72 hours after death with the Maryland liene r then "natural", or items 23e or 28e-f ehow The Medical Examiner must be notified at	al Director	10a. State 10b. County Maryland Montg 10e. Street and Number 242 West Deer P			.Town or Lo	sburg	Code			10g.	Citizen of What C	-
-0036	hours after dea tural', or items	ed by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	If Yes, Give Year or Dates:	?		1 🗆 Yes	2 X No	Specify:	in? (Specify Ye Puerto Rican,			ite, etc. Vhite
21215-0036	d within 72 piene. r then "nat	Completed	(Specify only highest Elementary/Secondary (0-12)		5+)	life.	kind of wo	ork done d se retired	lurina most o	of working		o. Kind of Business	,
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Maryland	should be nd Mental marked c matic eve	ဥ	Paris 19a. Informant's Name/Relationshi		hnson	19b Mailir	n Addres	s (Street a	and Number		tha Number C	ity or Town, State.	Ball Zin Code)
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Baltimore,	ages 1 nt of He r or oth		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation			ace of Dispo				Date		c. Location - City o	
altin	permit. Pages 1 Department of H important: if ite eny injury or ot		4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service Li	The second secon	Metr					10/21/0 DeVol		exandria, al Home	, Virginia
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Vit		o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpati	ent 2∏F	R/Outpatien	t 3 🗆 D0	Othe		of Death (Chec		e 6 □Other (Spe	aciful
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Division	P if i	Certification:	3 Suicide 6 Could no determin	ed 286. Place of In	jury - At hon tc. (Specify)	ne, larm, str	et, lactor	y, office			cation (Stree y or Town, S		ural Route Number,
	Hospital Z4 hours a Funerail etely filled	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the best kaminer: On the basis of and manner st	of examination	rledge, death on and/or inv	occurred restigation	at the tim	e, date and inion, death	place, and due occurred at th	to the caus le time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	To the within 2. To the complet	Me	29b. Signature and title ol certifier				29	c. License	number		29d.	Date signed (Mon.	th, Day, Year)
	10) Omst	Mo				000	057	954	00	रजेहिल	17 2005
	•		30. Name and address of person w	MD Som	DYC	ROUE	AC	ろいる	UT134	1 HOS A	JAIL		
31	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 0	2005 32 Registr	rar's Signatu	ure de	with the				-		

05-7170 B.K.S WILLIAM JACKSON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene O C

Physicia	an_	- State Amend item 1 Registrar 1. Decedent's Name (First, Middle, Las	st)			2. Date Mor	e of Death	Day Year	3. Time of Death
/Medic Examin	al	William 4a. Facility Name (If not institution, give PENINSULA REGIONA	street and number)	ackson NTER	Jr. 4b. City, Town, or Location SALISBURY	on of Death		4c. County of Dea WICOMIC	
Funeral Director	* 3	221-40-3343	ex Мм 2□F 7. Age (In) 48	vrs. last birthday) Yrs.	If Under 1 Year If Under 1 Months Days Hou	der 24 Hrs. 8. Date rs Min. 9/2	of Birth	9. Bir	thplace (State or Foreign ountry) Laware
e-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County Virginia Newport		. City, Town or Lo					10d. Inside City Limits 12√2 Yes 2 ☐ No
23a or 28	ai Director	10e. Street and Number 182 Alpine Street	et		10f. Zip Code 23606		10g. (Citizen of What Co USA	ountry?
Important: If item 27 le marked other then "naturel", or Itema 23a or 28e-1 ehow any injury or other traumatic event, it a Medical Evandrat must be notified at ones.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of Hispanic If Yes, specify Cuban, Mex 1 ☐ Yes 2 No Spec		s or No- atc.)	14. Race - Ame Black, Whit Specify: W	
then "natu te Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual Occupation kind of work done during ri DO NOT use retired)	3		Kind of Business	Utility Co.
irked other	To Be Co	17. Father's Name (First, Middle, Last) William Frank Ja			18. Mo	other's Name (First, andra Thon	Middle, Maid		•
er traum		19a Informant's Name/Relationship (Shari E. Jackson		19b. Mailii 182	ng Address (Street and Num alpine St.,	mber or Rural Route Newport N	Number, City	y or Town, State, . VA 23606	Zip Code)
lant: If item jury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	Park	la Memorial	Date 10/29/05	5 Ne	Location - City or ewport No	ews, VA
any in	٥	21 Signature of Funeral Service Licen		FSP 22	Hollowayss Fi 501 Snow Hil	Meral Hom 11 Rd., Sa	e Prof	essional y, MD 21	Association .804
etlanding physicien and direction as the burial-transit for use as the burial-transit	Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conduct. Due to (or as a conduct. Due to (or as a conduct. Due to (or as a conduct.)	sequence of):	ovascular Dis	sease			
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ate has	Completed					248	a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
	To Be	25. Was case referred to medical examiner? 1	Hospital: 1 ☐ Inpatient	2 XER/Outpatier	Other	lace of Death (Check Nursing Home 5		6 FlOther (See	noi6e)
After th funeral	Certification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Yea	28b. Time o		28d. De		jury occurred	wiy
eral Director:		3 Suicide 6 Could not be determined	building, etc. (Sp	ecify)		City	or Town, Sta	ate)	ural Route Number,
To the Funeral C	edicai	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2X Medical Exer	lysicien: To the best of my niner: On the basis of exam and manner stated.	nination and/or in	h occurred at the time, date vestigation, in my opinion,	e and place, and due death occurred at the	to the cause e time, date a	(s) and manner as and place, and due	s stated. e to the cause(s)
то т	Me	29b. Signature and title of certifier	Hace	einn	29c. License numb OCME	per		Oate signed (Mont CT. 24,	
		30. Name and address of person who 31. Date filed (Month, Day, Year)	completed cause of death	NWO	Print) 111 Penn	Street	Baltim	ore, Mar	yland 21201

Registrar

OCT 3 1 2005 Server & Spark

Kathy Hatfie 05-07230	1d	Krafthofer Unpend item#2	Type PIT Print	in Black	strejejibje ink	0- Ensu re A	II Copies	Are Legible.	0 7 -
crn		1 - For State Registrar	State of Man		epartment of F Certificate of			ieg. No.	35576
		Decedent's Name (First, Middle, La	st)				2. Date of Dea Month		3. Time of Death
- Physic /Medi	cal	Kathy Hatfie		ofer	41 01 7		October	25 200	5 9:41 P ^M
Exami	ner	4a. Facility Name (II not institution, given 4302 Mica Court	e street and number)		4b. City, Fown, o	or Location of Death	1	4c. County of De	
Funeral	-	5. Social Security Number 6.5		n yrs. iast birth			8. Date of Birth (Month, Day	Year) 9. Bi	irthplace (State or Foreign
Director		220-84-7260 Usual Residence of Decedent	1□M 2⊠F 4	4 Y	rs.		August	15,1961 Ma	ryĺand
yiand		10a. State 10b. County	10	Dc. City, Town	or Location				10d. Inside City Limits
Ba-fe	Director	Maryland Frederi	ck	1	Middletown				1 ☐ Yes 2 🔀 No
death with the Maryland me 23a or 28a-f ehow rmust be notified at	Dire	10e. Street and Number			10f. Zip Code	1760	1	log. Citizen of What C	·
death	Funeral	4302 Mica Court 11. Marital Status	12. Was Decedent Eve	er in U.S.	13. Was Decedent of H	1769 Hispanic Origin? (Sp	pecify Yes or No-	United St	nerican Indian,
36 safter	by Fu	1 ☐ Never Married 2 ☒ Married	Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give		1 ☐ Yes 2 ☒ No		o Hican, etc.)	Black, Wh	oite, etc. White
-000;	ed b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's E	Year or Dates:	16a. D	Decedent's Usual Occur	pation		16b. Kind of Busines	s/Industry
215 thin 72 Medic	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give kind of work done life. DO NOT use retire	during most of world	king	700. Tung or Dagings.	arridustry.
121 lied will tygien nt, Es	Con	12 17. Father's Name (First, Middle, Last			Homemaker	10 Marks de Marie	- /50 100		Home
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23a or 28a-1 e how applying or other traumatic event, the Medical Examinar must be northed at each industry or other traumatic event.	To Be	Phillip Hatfield	•				ie Fanni	Maiden Sumame)	
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and 2 ealth in 27 i		Edward B. Kraftho	the second secon	the second second	02 Mica Co	urt Midd			
ages 1 por or of the		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery	Disposition (Name of crematory or other pla	cθ) Qctc	ber	20c. Location - City o	
ulting nit. Pa entmen ortant injury		4 ☐ Donation 5 ☐ Other (Special Service Lice		Parklav	wn Mem. Par	k 29,	2005 F	Rockville, uneral Hom	
		122	Ita		8 E. Ridge	ville Blv	d. Mt.	Airy, Mar	yland 21771
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ritificating physics the	Medi	IF FEMALE:							
Division of Vital Records, P.O. Box 68760, for attending Physicien: The law requires that the death certificate be exampled to safe. Director: After this certificate has been signed by the attending physicien in by the funeral director, page 2 should be detached for use as the burial in by the funeral director, page 2 should be detached for use as the burial	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	Fetal death	3 DEctopic pregnance	y		23d. Date of de Month	elivery Day Year
P.O. that the defect by the defect bed	nysic	1 □ Yes 2 □ No 9 XUnknown	4□Pregnant at tim 9□ Unknown	e of death	5 Other (specify)				
is, P	by P	Part II. Other significant conditions	contributing to death but n	not resulting in	the underlying cause giv	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
Cord w require been si	ted	Fatty Metamorphos	is of the L	iver			1 🗆 Yı	es 2 No 3 F	Probably 4 Unknown
Recipients of the second of th	Completed						24a. Was a autops perform	sy prior to	autopsy findings available completion of cause of
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f Vi nysich nis cert direct	To Be	examiner? 1 XYes 2 No	Hospital:	2 ER/Outp	patient 3 DOA Oth	or	th (Check only on ome 5 Reside	λ	at scene
Ing Pl		27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Injury (Month, Day Y	ear) 28b. Tii	jury Wo		28d. Describe ho	ow injury occurred	
Attend death ctor:	ficat	3 Suicide 6 Could not b	00 Place of Injury	- At home, farr	M 1	Yes 2 □No	28f Location (Si	treet and Number or F	Rural Route Number
Div	Certification:	4 Homicide determined	building, etc. (Specify)	n, sirest, radiory, silies		City or Town	n, State)	TODIO TENNOST,
Division of Vital Revision of Vital Revision of Vital Revision of Vital Revision of the House after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		(Chock only 212 Madical Exa	hysician: To the best of n	amination and	death occurred at the til	me, date and place, ppinion, death occui	, and due to the corred at the time. d	ause(s) and manner a	as stated.
o the P ithin 24 o the F omplete	Medical	one) 29b. Signature and title of certifier	and manner stated	1.	29c. Licens			9d. Date signed (Mor	
● ► ≥ E 3		Moto . ()	Um. 1/4.	Klo		ME	4	October 26	,
_		30 Name and address of person who	completed cause of deat	h (Item 23a) (T	Type, Print) 111 F	enn Stree			yland 21201
		31. Date filed (Month Day, Year)	Drich to	Signature	no				
Regis	ate trar	NOV 0 1 2	005	, J.	Good				

State of Maryland / Department of Health and Mental Hygiepe 0 5 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2^{Day} **Physician** Wayne E. Keplinger /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Imberlance of Year If Under 24 H MEART SACred Oita HILLEGAN 5. Social Security Number . Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days Min Months Hours 1 M 2 ☐ F Director 236-44-7073 75 6/28/30 WV Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location or iteme 23a or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Funeral Director 1 TyYes 2 ☐ No Minera1 Keyser 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 182 C Street 26726 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Mind Folces:

Pares 2 No
If Yes, Give

Year or Dates: Korean 1 Never Married 25 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No þ Specify: Specify: white 3 Widowed 4 Divorced naturai Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th permit. Pages 1 and 2 should be filed w Depertment of Health and Mental Hygier Important: if item 27 is marked other the eny injury or other treumatic event, the page. Papermaker Pulp & Paper Co. 17. Father's Name (First, Middle, Last) Be (18. Mother's Name (First, Middle, Maiden Surname) Jeff L. Keplinger Evelyn Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Keplinger/wife 182 C Street, Keyser, WV 26726 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lahmansville 11/02/05 Lahmansville, WV 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Markwood Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Box 912, Keyser, WV Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed if the death. ettending physicien and for use as the burial-transit Box 68760, Due to (or as a consequence of) Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4 Pregnant at time of death Year Day 5 Other (specify) Division of Vital Records, P.O. ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Yes 2 1 ☐ Yes 2 ☐ No ours effer death.

Neral Director: After this certification by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ninpatient 2 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 □Yes 2 □No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To the Hospital within 24 hours e To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RFELIP Bishop 31. Date filed (Month, Day, Year) §32. Registrar's Signature State Registrar 2005

State of Maryland / Department of Health and Mental Hygie 2e 05 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 0118 18 Elizabeth Ann Keyes 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Mormica Pekinsula 34/13641 Regional If Under 1 Year If Under 24 Ars. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 214-42-8726 1943 Maryland Director April 15, Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ral', or Itama 23a or 28a-f show Exeminer must be notified at 1 ☐ Yes 2 No **Funeral Directo** Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 612 Twin Point Cove Rd. 21613 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 No Specify: Yes. Give Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural", Completed la marked other than "natur aumatic avant, the Madical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 11201 BETH Elementary/Secondary (0-12) College (1-4or 5+) service manager automotive 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Walter F. Yoor Rose Elizabeth Foble 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: if Item 27 la any Injury or other trau 2002. husband 612 Twin Point Cove Rd., Cambridge, MD 21613 Donald H. Keyes Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Spedden Seward Cemetery 10/21/05 Cambridge, MD 21. Signature of Funeral Service Lipensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD Approximate Interval Between Onset and Death 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** /Medical **Examiner** myocardial inferction anterslatina Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine attending physicien end for use as the burial-transit or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): artery that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed (es 2 No 1 Yes within 24 hours after deeth.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce 2 10/18/05 D41721 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALISBURY MO 21804 400 E. SILDRE STEPHAN PAVLOS MD DR. 32. Registar's Signature 31. Date filed (Month, Day,) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

42

State of Maryland / Department of Health and Mental Hygiepe 0.5Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month October 0 2005 Emma Butler Kemether 0356 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Union Hospital E1kton Ceci1 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year AUG 21, 19 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 💢 F Yrs Director Delaware 85 1920 216-12-8095 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits treumatic event, the Medical Examinar must be notified at 1 X Yes 2 No Ceci1 Maryland E1kton Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 238 10 Jesse Boyd Circle 21921 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 \ Widowed 4 □ Divorced White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "no Elementary/Secondary (0-12) College (1-4or 5+) Hostess/Manager Restaurant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ပ John R. Butler Lucy Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s nent of Health an item 27 i Betty Jo Trexler/Daughter 10 Jesse Boyd Circle, Elkton, Maryland 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Location - City or Town, State Chesapeake City, 20a. Method of Disposition October 27, permit. Pages Depertment of I Important: If Its any injury or o once. 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Bethel Cemetery Maryland 21. Signature of Funeral Service Licensee Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, Maryland 21921 (ask 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician phinoto we? K /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause, [Lisease firjury that initiated events resulting in death) Last certificate be executed the attending physician and hed for usa as the burial-transit 68760, Physician/Medicai IF FFMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.O. à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, 3 Probably 4 □Unknown cate has bean sig , page 2 should b 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performed? 1 Yes 2 24b. Were autopsy findings available prior to completion of cause of death? certificate has 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one examiner' Hospital: 2 ☐ ER/Outpatient 2 2 No Other: ည 1 🗌 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA this 27. Manner of Death Dale of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After Division 1 Natural
2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation or Attend after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours at To the Funarel D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) esaygon 31. Date filed (Month, Day, Year) State Registrar NOV O

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		•	1 - State Registrar	tate of M	larylan	d / Dep <i>Ce</i>	artment of F	lealth a Death	and Menta		ene () ()5	35580
X	Physicia	an	Decedent's Name (First, Middle, Last)						2. Date Mor	e of Death	Day	Year	3. Time of Death
	/Medic	al .			KIMME	L	T			ober	25,	2005	11:15 P M
-3	Examin	er	4a. Facility Name (If not institution, give street				4b. City, Town, o		of Death		4c. County		
	-	SE-2	Frederick Memorial 5. Social Security Number 6. Sex	Hospi 7.A		last birthday	Freder:		24 Hrs. 8. Date	e of Birth	Fred	erick	place (State or Foreign
te .	Funeral Director		212-38-9027 ¹□м		64	Yrs.	Months Days	Hours	Min. Nov	nth, Day, 1	1 940	Mar	yland
	p ,		Usual Residence of Decedent		T40 00							·	
	arylar ehow	_	Maryland Frederick			y, Town or L rederi						1	0d. tnside City Limits 1 ☐ Yes 2 ☐ No
	the M	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of	What Cour	
	filed within 72 hours after death with the Maryland Hygiene. Hygiene, then "natural", or items 23a or 28a-f ehow ther then "natural", or items 23a or 28a-f ehow ent, the Madical Examiner must be notified at		250 West Fifth	Street,	, Apt	. 3	21701			1	U.S.A.		,
	death	Funeral		Was Decedent	t Ever in U.		Was Decedent of H If Yes, specify Cuba	lispanic Orig	gin? (Specify Ye	s or No-		ce - Americ	
9	after or ite	F	1 ☐ Never Married 2 🔀 Married	1 ☐ Yes 21☐ If Yes, Give			1 Yes Y No	Specify:	i, Fuerto Filozri, e	sic.)		ck, White, by: Whi	
9	hours ural',	d by	3 Widowed 4 Divorced	Year or Dates:		10.0							
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212	d with giene. r ther	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	Clear	ning Perso	on			Clean	ing S	ervice
힏	al Hyg	Bec	17. Father's Name (First, Middle, Last)						er's Name (First,				
ylaı	ould b Ment Ment warked	To I	Lester Verno						Marie El				
, Mar	and 2 shalth and alth and 27 ie m		19a. Informant's Name/Relationship (Type, Mrs. Susan M. Morga		ghter		ing Address (Street Stonegate						Code)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The many injury or other treumatic event, the Madical Examiner must be notified at once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Rem. 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	c	emetery_cre	osition (Name of matory or other place Cemetery	o) Oct	Date 28, 20		New Ma		
Balti	permit. Departn Importe any Inju		21. Signature of Funeral Service Litensee	1	MOO:	255 1	Keeney and Addre Keeney ar 06 East (id Bas hurch	ford PA Street	Fune Fre	ral Ho derick	ome k, MD	21701
· 沙·			23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one of	ons that cause	d the deat	h. Do not er	iter the mode of dyir	such as	cardiac or respir	atory arres	t,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition									1	Onset and Death
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Division of Vital Records, F	es this gned be de	by	Part II. Other significant conditions contrib	uting to death	but not res	ulting in the	undertying cause giv	en in Part I.	23	_			ne cause of death?
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æ	The lav	mo					110		10	autopsy perform Yes 2	ed?	death?	mpletion of cause of
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<u>></u>	hysic his ce I direc	70	examiner? 1 Yes 2 No	1 🗀 Inpat		ER/Outpatie	nt 3□ DOA Oth	er: 4 🗆 Nu	rsing Home 5[Residen	ce 6 Oth	ner (Specif	y)
o u	Attending Physician: r death. sctor: After this certifice by the funeral director.		27. Manner of Death 1 ☑Natural 5 ☐ Pending	8a. Date of Inj (Month, D.	ury ay Year)	28b. Time Injury	Wor			scribe how	injury occur	red	
isio	ttend death stor: / the f	Icat	2 Accident investigation 3 Suicide 6 Could not be	In Plans of In	niume. At he	ama fare a		Yes 2 🔲		ation (Ctro	at and Mumi	has as Over	I Courte Alicente
Ω̈́	s after s after si Direct	Certification:	4 Homicide determined	building, e	etc. (Specifi	y)	treet, factory, office			or Town,		oer ar Hura	il Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier 1 Certifying Physici (Check only one) 2 Medical Examiner.	on: To the bes On the basis and manner s	of examina	wledge, dea tion and/or i	th occurred at the tir nvestigation, in my o	ne, date an pinion, dea	d place, and due th occurred at th	to the cau e time, dat	se(s) and m e and place,	anner as s and due to	tated. o the cause(s)
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	6		30. Name and address of person who comp				, Print)				D 04=	20	
1	Sta	te	Michael Costello 31. Date liled (Month, Day, Year)		, LD84 trar's Signa		sumtown l	ıke,	rrederi	ck, M	D 21/()2	
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			For State Registrar	State of	of Marylar		artment of tificate of			lental Hy	giene	5	35581
ı	Physici /Medic		1. Decedent's Name (First, Middle John	, Last)	azik					2. Date of De Month Octobe	er 10, 2	2005	3. Time of Death 11:28 A M
	Examir		4a. Facility Name (If not institution 265 A Konrad M				4b. City, Town	or Location Othian			4c. County	of Deat	
	Funeral Director		5. Social Security Number 041-20-4121 Usual Residence of Decedent	6. Sex 1 	7. Age (In yrs. 78	last birthday) Yrs.	If Under 1 Year Months Day		24 Hrs. Min.	8. Date of Bi (Month, Da Jan 30	o, 1927	9. Birtl Co Co	hplace (State or Foreign untry) DNN •
	Maryland I-f show	tor	10a. State 10b. County	Arundel		ity, Town or Lo	cation						10d. Inside City Limits 1 ☐ Yes 2 X No
	with the	I Director	10e. Street and Number	TOOD	003		10f. Zip Code 207				10g. Citizen of		untry?
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itams 23a or 28a-f show aumatic event, the Medical Examinar rotat by notified at	by Funeral	265 Boones Ex 11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was Dec	edent Ever in U prces? 2 ☐ No ve		Was Decedent of Yes, specify Cu	Hispanic Or ban, Mexicai		ecify Yes or No Rican, etc.)		ce - Amer ck, White	ncan Indian, e, etc. White
21215-0036	within 72 ho ene. than "natur he Medical	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)		1-4or 5+)	(Give	lent's Usual Occ kind of work don DO NOT use retii	e during mos ed)		ng	16b. Kind of B		
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altimore, A	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other traumatic a angog.		Thomas Lazik (20a. Method of Disposition 1 Burial 2 Cremation	3 Removal from	State _	Place of Dispo cemetery, cren	Oaklar Sition (Name of natory or other pi	ace)	C	ate	20c. Location	City or 1	
Baltin	permit. Pa Departmen Important any injury		' 4 □ Donation 5 □ Other (S) 21. Signature of Funeral Service I					ress of Facili	y Lee		al Home	Calv	eryland Vert, PA MD 20736
ì	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	complications that conly one cause on e	each line.	th. Do not ente	er the mode of dy	ring, such as	cardiac o	r respiratory a			Approximate Interval Between Onset and Death
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68760,	ificate be executed g physician and as the burial-transit	edicai		dh	yper	chole	skrole	mi	٠ د				
O. Box	The law requires that the death certifin te has been signed by the attending rage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live b	tcome of pregnation of court at time of court	al death 3	Ectopic pregnan Other (specify)	су			23d. Da Mo	te of deliv	very Day Year
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DIVISION	To the Hospital or Attendi within 24 hours after death To tha Funaral Diractor: A completely filled in by the fu	O	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ned 289. Place buildi	ng, etc. (Specii	(y) 	eet, factory, office			City or Tov	vn, State)		ral Route Number,
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	within To II comp	Σ	29b. Signature and title of contine	much	m	1>		se number			29d. Date signed		_
1	D		30. Name and address of person v	who completed caus	se of death (Iter	n 23a) (Type, F			IN	ect R			
İ	Sta Registr		30. Name and address of person vestice F. By 31. Date filed (Month, Day, Year)	1 7 2005)	egistra signa	ature #	Charle	•	, , , ,	31 1-6	7	U	20170

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day 17 Joan Lanphear 2005 October | 7:02 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 656 Maid Marion Hill Sherwood Forest Anne Arundel If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1 ☐ M 2 😿 F Director Yrs 304-22-7339 82 Indiana May 4, 1923 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at Completed by Funeral Director Anne Arundel 1 ☐ Yes 2 → No Sherwood Forest 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 656 Maid Marion Hill 21405 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2) No Specify. White 3XXVidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be pe t and Mental I 2 Ray S. Winey Margarette Keys 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 I Ann K. Lanphear (Daughter) 5106 Mangum Road, College Park, MD 20740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If Ite any Injury or ot 2002 1 ☐ Burial 2XXxremation 3 ☐ Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) Metro Crematory 10-19-2005 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the lise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm diate Cause (Final diseate or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and for use as the burial-translt law requires thet the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 Fetal death in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) ed by the a P.O. 9 Unknown certificete has been signed irector, page 2 should be del Part II. Other significant/equditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2. No Completed 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform res 2 2 No 1 ☐ Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Hesidence 6 Other (Specify)
Injury at 28d. Describe how injury occurred 1 🗌 Yes 2) No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide 0 within 24 hours e To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check one) 29b. Signa 0 29c. License numbe 29d. Date signed (Month, Day, Year) 30. 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiepe 15 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Yeer **Physician** PATRICIA FLORENCE LEDNUM 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner REGIONAL MEDICA HICOMICO SA/13/4/14 Hennsula 8. Date of Birth (Month, Day, NOV - 7 If Under 1 Year 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 6. Sex Social Security Number **Funeral** Min Months Days Hours 1 □ M 2 X F MARYLAND Director 220-26-1393 74 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County or items 23a or 28a-f ehow other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ▼ No Director HURLOCK MD DORCHESTER 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6446 SUICIDE BRIDGE ROAD 21643 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2X Married Maryland 21215-0036 1 Yes 2 No Specify: þ Specify: WHITE 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other then ' Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be GEORGE DEWEY FAULKNER **EVELYN DAVIS** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CHARLES KENNETH LEDNUM/HUSBAND 6446 SUICIDE BRIDGE ROAD, HURLOCK, MD 21643 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 0 TILGHMAN MEMORIAL CEM 10/27/2005 TILGHMAN, MD * 4 ☐ Donation 5 ☐ Other (Specify) eny injury 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON ST EASTON, MD 21601 21. Signature of Funeral Service Licensee VOITN K MERCERO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OREM FAWRE 241485 **Physician** a MULTIPLE S-KETTEM resulting in death) /Medical Due to (or as a consequence of): **Examiner** CORMARY MOTERY BYPASS 20mys BETIC VALUE REPLACEMENT obquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed c. ADRATIC STENCEIS COLONARY ARTERY and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as the the attending IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year detached for Dav 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 2/2 No 1 ☐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Natural 2 Accident 5 Pending Injury 1 Tes 2 🗆 No within 24 hours after death. To the Funerel Director: A investigation 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 22225 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ancs Carroll Todd 31 Date filed (Month. Day, Year) Registrar's Signature State OCT 2 5 2005 Registrar

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Physicia		1. Decedent's Name (First, Middle, Last)	1 186	SER		2. Date of Deat Month		3. Time of Death
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ours aft	þ	Armed Forces 1 □ Never Married 2 □ Married 1 □ Yes 2 □ N 3 ☒ Widowed 4 □ Divorced Armed Forces 1 □ Yes 2 □ N Year or Dates:	0	If Yes, specify Cuba 1 ☐ Yes 2 🔀 No	n, Mexican, Puerl	o Rican, etc.)	Specify: WI	e, etc. HITE
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uld be f Mental H Irked of	To Be	SAMUEL GREEN					NASCERTAINA	ABLE)
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To the Hospital or Attending Physician: The law within 24 hours after death, To the Funeral Director: Attent his certificate has completely filled in by the funeral director, page 2.	edical Cer	29a. Certifier (Check only (Ch	examination and/	death occurred at the tim	ne, date and place pinion, death occu	, and due to the ca	use(s) and manner as	stated. to the cause(s)
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Maryland	should be nd Mental marked c	10	Solomon Lewis 19a. Informant's Name/Relationship	(Tuna Print)	10	h Mailin	a Addrass (Street	and Number or Run	Margol		or Town State 2	in Code)
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5%	he dez	Physician/M	1 Yes 2 No	4☐ Pregnant a 9☐ Unknown	at time of death	5 🗌	Other (specify)				77.07.5	July 1541
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Sign	al or Attends after death	Certification:	4 Homicide determine		itc. (Specify)	arm, sire	вы, таскоту, опісы		City or To	wn, State	e)	rai nobie ivuitbei,
	To the Hospitel or within 24 hours after to the Funeral Director Completely filled in b	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best	of examination a	je, death nd/or inv	occurred at the ting	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s)	and manner as d place, and due	stated. to the cause(s)
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-	•		30. Name and address of person wh	o completed cause of	death (Item 23a)	(Type,	Print) TH 甘(e01 de	ckville	~	10.20	852
V	Sta		31. Date filed (Month, Day, Year)	2005 Gdu	trar's Signature	Ans	reles					
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** рм James Alexander DeLisboa October 15, Lopes 2005 9:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner National Institutes Of Health Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Months Hours Min. X M 2 □ F Yrs Director 577-19-1664 Jan. 14, 1990 Washington, Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location ehow. 10d. Inside City Limits the Medical Exeminer must be obtilied at 1 Yes 2 No Directo Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3705 Greenly Street or Iteme 23a 20906 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. I the Important: If item 27 is marked other than "neturel; or Item eny injury of other traumatic event, the Maxifical Examinant one. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes. Give 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Student High School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jose Antonio Martins Lopes Julia Maria DeLisboa 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jose Antonio Martins Lopes/Father 3705 Greenly Street, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State October 20, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2005 Alexandria, Virginia 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc Will Exposes 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a. Hypoxemia disease or condition resulting in death) 20 Hours /Medical Due to (or as a consequence of): **Examiner** Undifferentiated Sarcoma- Metastatic 2.5 Years if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760 by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in lihe underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🔀 No **Division of Vital** 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🔀 No 1X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Certification: 28c. Injury at Work? 1 X Natural 5 Pending 2 Accident investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D57423 October 17, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kristin Baird, M.D. 10 Center Drive, Bethesda, MD 20892 31. Date filed (Month, Day, Year) 32/Registrar's Signature State OCT 2 0 2005 Registrar

State of Maryland / Department of Health and Mental Hygiepe | 35587 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** АМ 17 2005 9:39 October SHIRLEY SANDRA LYNNE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, June 12 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sax **Funeral** 1 □ M 2 🖾 F 1922 Brooklyn, 83 **Director** 089-16-5709 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State rel', or Items 23e or 28e-f show Exercises must be notified at 1 ☐ Yes 2 No Silver Spring MD Montgomery Director the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States of America 20902 2014 Glenhaven Place Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes, Give 1 Never Married 2 Married 2 No Specify: Caucasian Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: 3 Widowed 4 Divorced "neturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netunenty injury or other treumatic event, the Medical once. 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) County Government 5+ Board Member 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Nettie Feinberg David Jacobson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2014 Glenhaven Place, Silver Spring, MD 20902 Diane S. Lynne - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Mt. Lebanon Cemetery 10-20-2005 Adelphi, MD 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licens 11800 New Hampshire Ave Silver Spring MD 20904 23a Part1. Epler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, specific or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hypertrophic Cardiomyopathy Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Tyes 2 XNo 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed Aortic Insufficiency peen : 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has certificate 1 Yes 2√ No in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Certification: To this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death After Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. s after death 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide filled 24 hours a (X) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ica 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely To the within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie, D0052069 October 17, 2005 15 30. Name and address of fers in who completed cause of death (Item 23a) (Type, Print) 10313 Georgia Avenue, Suite 306, Silver Spring, MD 20902 Julie Krivy, M.D. 31. Date filed (Month, Day, Year) egistrar's Signature State OCT 19 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieric] 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Philomene Lucy Marshall 20, 2005 1625 Oct. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Atlantic General Hospital Berlin Worcester 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M X F 79 Yrs. Director 032-16-4544 Feb. 14, 1926 NÝ Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "netural", or items 23s or 28e-f show other traumatic event, the Medical Examinating must be modified at 1 ☐ Yes 2 No Director Worcester Newark 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 8432 Newark Rd. 21841 US Funerai 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 2 should be filed within 72 hours after and Mental Hygiene. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: 3 X Widowed 4 □ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Anthony Vigneault Florence Jordan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 si Department of Health and Important: If item 27 Is r any injury or other traur Paul Marshall (son) 8432 Newark Rd., Newark, Md. 21841 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 10-27-2005 Nashua New Hampshire St. Aloysius Cem. 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licensee 108 William St., Berlin, Md. 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) perhaloma Pnysician /Medical as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of, Due to (or as a consequence of) 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown O 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 2 100 or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ō 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ision 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \(\text{Homicide} \) within 24 hours a Hospital

State

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K Eaver

29b. Signature and title of certifier

29a. Certifier

(Check only one)

Medical

person who completed cause of death (Item 23a) (Type, Print)

9733 Healthway Dr Berlin MD 21811

29d. Date signed (Month, Day, Year)

10/20/05

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D53612

Registrar

		-	For State Registrar	State of Maryla		artment of Healt ctificate of Dea		lygiene Reg. No.	005	35589
	Physicia		1. Decedent's Name (First, Middle, Last) Blanche	Ε.	Mat	thai	2. Date of Month Octo	Day	8 2 ^{Year} 5	3. Time of Death 10:30p M
	/Medic Examin	9.5	4a. Fecility Name (If not institution, give st	reet and number)		4b. City, Town, or Locat	ion of Death	4c. (County of Death	
			3336 Solomons Isla	and Road		Edgewate			Anne Aru	
	Funeral Director		5. Social Security Number 6. Sex 1□	- V-	s. last birthday) 36 Yrs.	If Under 1 Year If Ur Months Days Hou	or and a second	Birth Day, Year) 15, 19	9. Birtho Cour 19 Mary	place (State or Foreign ntry) 1 Land
	pue *	}	Usuel Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	cation				10d. Inside City Limits
	f sho	ō	MD Anne Arui	nde1	Edgewat	er				1 ☐ Yes XXNo
	28a-	Director	10e. Street and Number			10f. Zip Code		10g. Citiz	ten of What Cour	ntry?
	h with		3336 Solomons Isla	and Road		21037			USA	
21215-0036	72 hours after death with the Maryland natural; or Items 23a or 28a-f show digal Exacilist most be notified at	by Funeral		2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	"	Was Decedent of Hispanie of Yes, specify Cuban, Me 1 ☐ Yes 2 ☒ No Spe	kican, Pueπo Hican, etc.		4. Race - Americ Black, White, Specify: Wh	
5-0	72 ho	eted	15. Decedent's Educi (Specify only highest grade		(Give	dent's Usual Occupation kind of work done during	most of working	16b. Kir	nd of Business/In	dustry
121	C 3	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired)		R	etail	
5	filed within Hygiene. othar than		17. Father's Name (First, Middle, Last)		5000		fother's Name (First, Mic			
an	Mental Mental arkad o	To Be	Raymond Hardesty			D	aisy Cox			
Maryland	S D E E	-	19a. Informant's Name/Relationship (Typ	e, Print)		ng Address (Street and N				
	1 and 2 Health a tam 27 is		Nellie Parlett (D			Solomons Is				
Baltimore,	00		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Re 14 □ Donation 5 □ Other (Specify)		cemetery, crei	sition (Name of natory or other place) ville UM Cem	Date 10-21-200		cation - City or To dsonvil	
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Scores		22	2. Name and Address of F Hardesty Fu 12 Ridgely	neral Home,	P.A. apolis	, MD 214	401
	Physician /Medical Examiner	_	23a. Part1. Enter the disease, or complice shock, or heart failure. List only one disease or condition resulting in death) Sequentially list conditions,	ations that caused the decause on each line. Due to (or as a cons	equence of):	er the mode of dying, suc	h as cardiac or respirato	ry arrest,		Approximate Interval Between Operate and Death
0,	cate be executed physician and the burial-transit	Examiner	if any, leading to immediate cause. End underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons						
68760,	ate be nysicii he bu	dlcal	d.							
P.O. Box 68	ne death certifi the attending hed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Yoo 9 ☐ Unknown	c. If yes, outcome of prec 1 Live birth 2 Fe 4 Pregnant at time o	etal death 3	□Ectopic pregnancy □ Other (specify)		_ 2	23d. Date of delive Month	ery Day Year
	luires that the signed by ald be detacted	by	Part II. Other significant conditions conf	ributing to death but not r	resulting in the u	nderlying cause given in F			se contribute to t □No 3□Prot	the cause of death?
Records,	The faw requir te has been s page 2 should	Completed					a	Vas an utopsy enformed?	prior to co death?	opsy findings available impletion of cause of
Vital		Be C	25. Was case referred to medical examiner?			26. 1	Place of Death (Check of			
of V	Physician: this certific ral director,	P	1 □ Yes No		☐ ER/Outpatier				Other (Specia	5y)
	fing After fune	atlon:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injury at Work? M 1 □ Yes		ibe how injury	y occurred	
Division	al or Attandi s after death. al Diractor: A ad in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - Ai building, etc. (Spe	t home, farm, st ecify)	reet, factory, office		on (Street and Town, State)		al Route Number,
	To tha Hospital or Attanding Ph within 24 hours after death. To tha Funeral Diractor: After th completely filled in by the funeral	Medical	(Check only -2 Medical Examin	cian: To the best of my ker: On the basis of examand manner stated.	ination and/or in	vestigation, in my opinion	, death occurred at the ti	me, date and	place, and due t	o the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	npleted cause of death (I		29c. License num	ber	29d. Date	e signed (<i>Month</i> .	Day, Year)
			30. Name and address of person who cou	mpleted cause of death (I	tem 23a) (Type,	ler RZ	Glen Burn	ne, r	nd., 20	1060
		ite	31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature			(/	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Items#9,17,3,18, per land / Separtment/05Hearth and Mental Hygiere 05

1- State Registrar AACO HEALTH DEPT CMH Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Yea **Physician** Mulligan 2005 October | 12 5:54 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner ANE Home Care Assisted Living Glen Burnie
If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Anne Arunde1 9. Birthplace (State or Foreign Country Michigan 8. Date of Birth (Month, Day, Year) Dec. 19, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months 1 M 257 Yrs. Ĩ913 028-03-5590 Masea Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X **Funeral Director** Anne Arundel Glen Burnie 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1224 Cathedral Drive 21061 USA 12. Was Decedent Ever in U.S. Armed Forces? LNK 1 Xyes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ◯XNo Specify: White Completed by 3€XWidowed 4 □ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry H. Bering Unknown Ida G. Dawe Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 134 I Sloane Drive, Glen Burnie, MD 21060 Raymond Lang (Friend) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Oct 28,2005 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat. Cem. unk Arlington, Virginia 21. Signature of Funeral Service Lice 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final CARDIAC ARREST MINUTES disease or condition resulting in death) Due to (or as a consequence of): HYPERTENSIVE HEART DISEASE EARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MERLITUS 1 ☐ Yes 2 📉 Vo 3 Probably 4 Unknown B ETE S 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No MENTIA 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Assisted Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Living 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

/Medical Examiner burial-transit The law requires that the death certificate be executed

Funeral

Director

or 28e-f show

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or Items

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Hygiene.

Pages 1 and 2 should be fill ment of Health and Mental Hient: If item 27 Is marked other:

other treumatic event,

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permit. Page Department o Importent: If any injury or once.

Physician

filed within 72 hours after death

Baltimore, Maryland 21215-0036

the Madical Examiner must be notified at

Box 68760, phys the as esn ed by the a detached f P.0. Records, sign be c Division of Vital the Hospitel or Attending Physicien: director After thi within 24 hours after deam.

To the Funerel Director: Af

> State Registrar

Medical

WASTACIO 31. Date filed (Month, Day, Year) 2 0 2005

(Check only one)

29b. Signature an

E SUBONG 32 Registrar's Signature

Nume and advess of person who completed cause of death (Item 23a) (Type, Print)

206 CRAIN HWY S.W G.B., HD, 2106/

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D02583

29d. Date signed (Month, Day, Year)

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			For State Registrar	5	State	of Maryla				lealth a Death		ental F	lygie		5 3	3559	
			1. Decedent's Name (First, Middl	e, Last)							1	2. Date of	Death			3. Time of	Death
	Physicia /Medic		Donald Eugene	More	an						0	Month		ay 19 2	Year 2005	0545	М
	Examin		4a. Facility Name (If not institution	n, give str	eet and n	umber)		4b. City,	Town, or	r Location	of Death		4	lc. County		1	
			Chester River	Hosp	ital			Chest	tert	own			ŀ	(ent			
	Funeral		5. Social Security Number	6. Sex		7. Age (In yr.	s. last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. 8	B. Date of	Birth Day, Yea	ur)	9. Birtho	lace (State or	Foreign
	Director		215-40-7783	1 (A) N	/ 2□F	63	Yrs.	IVIOITAIS	Dayo	1100.0		an. 2		942		land	
	p ,		Usual Residence of Decedent 10a, State 10b, County	,		100 (City, Town or Lo	nation								Od Jacida Cit	a I tasita
	shov	-						Cation								0d. Inside Cit	
	Be-f	Scto		ferso	n	<u> </u>	rinnon						1				
	or 2	Directo	10e. Street and Number					10f. Zip	Code					Citizen of W		,	
	ath v	a	251 River Road						3320					ited			
	hours after death with the Marylend turel', or Items 23s or 28e-f show at Exercinet must be notified at	Funeral	11. Marital Status		Armed F			Was Deced	dent of H	ispanic Ori an, Mexicar	gin? (Spec n, Puerto R	ify Yes or ican, etc.)	No-		e - Ameno k, White,	an Indian, etc.	
36	s aff	by F	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 47 ☐ Pivorced		113/ 6	2 □ No Sive Dates: 195	9-1962	1 🗌 Yes	2 K No	Specify:				Specify	whi	te	
Ş	hour	edt	15. Deceder			Dai: 175	16a. Dece	dent's Usua	al Occun	ation			16h	Kind of Bu	siness/In	dustry	
5	in 72 " na'' r	Completed	(Specify only highe	st grade o	completed		(Give	kind of wo	rk done d se retired	during mos	t of working	g	100.	TRAITE OF DE	0111000	adony	
12	within iene.	E O	Elementary/Secondary (0-12)		College	(1-4or 5+)	Mer	chant	Sea	aman			S	hinni	no C	ompany	
ō	filed Hyg other	Be C	17. Father's Name (First, Middle,	Last)							er's Name ((First, Mid		en Sumam		op carry	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylen if Health and Mental Hygiene if Health and Mental Hygiene items 23s or 28e-1 show item 27 is marked other than "natural, or items 23s or 28e-1 show other treumatic event, the Medical Esserings must be notified at	To B	Jesse James Mo	rgan						Mar	y Eli	zabet	h Da	vis			
37	shound No	_	19a. Informant's Name/Relations	hip (Type	, Print)		19b. Maili	ng Address	(Street	and Numbe	er or Rural	Route Nu	mber, City	or Town,	State, Zip	Code)	
	nd 2		James Morgan/ h	roth	er		1192	Hamr	ton	Road	Anna	nolis	MD	2140	1		
ē,	f Hei		20a. Method of Disposition				Place of Dispo	sition (Nar	ne of	4	Da	ite		Location -		wn, State	
Ę	Page ent o nt: ff ry or		1 XBurial 2 ☐ Cremation 1 Donation 5 ☐ Other (5		noval fron	n State La	kemont				10-24	4-200	5 D	avids	onvi	11e. M	D
altimore,	permit. Pages I Department of H Importent: If Ite any Injury or ot		21. Signature of Funeral Service			1										1 Home	
ä	Depariment Department Important In any ir conce.		1 L. Sesti	Kom	ant	×4										MD 21	
			23a. Part1. Enter the disease, o shock, or heart failure. List	r complica	tions that	caused the de	ath. Do not en	er the mod	le of dyin	g, such as	cardiac or	respirator	y arrest,			Approximate Interval Betw	1
	Physician		Immediate Cause (Final	Offig Offe	LAUSE OIL	Own no	CT	R) -	1.							Onset and D	eath
	/Medical		disease or condition resulting in death)	a	Due to	o (or as a cons	equence of):	שקכי	AIN	1		-			-	29 hz	3.
	Examiner				ก	NHMO		られた	ml.							48 h	7
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying] D		o (or as a conse		,,,,,					-			^	
	outed Id ransil	Examln	that initiated events) c.	L	una	Cance	~	non	Sma	11 0	ill				2 M	YS .
ó	en ar		resulting in death) Last		Due to	o (or as a conse	equence of):				-					2	
8760,	cate be executed physicien and the burial-transit	dical		d.	- 1	Source	atic 1	M45	5							SW	rs.
9	ng ph ng ph s as ti	O I	IF FEMALE:														
Вох	death certific e attending p ed for use as	an/I	23b. Was decedent pregnant	230		utcome of preg birth 2 Fe		Ectopic pr	egnancy	,				23d. Date Mor	e of delive	,	
	e dea he at ed fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No		4☐Preg	gnant at time of nown	death 5	Other (sp	ecify)				-	MO	1111	Day Y	ear
P.0	that the de led by the a detached f	Physician/M	9 Unknown				M. I. II					20. 0					
	igned bed	by	Part II. Other significant conditi	ons contr	ibuting to	death but not r	esuiting in the u	naeriying c	ause giv	en in Part I						ne cause of de	
ord	v requir been s should	ted				····				_		1	☐ Yes	2 000	3 L Prob	ably 4 🗆 U	лкпоwп
ec	2 5 2	ompleted										24a. W	as an stopsy			psy findings a	
Vital Records,	<i>a</i> □	Соп										1 ☐ Ye	arformed? s 2'5√		eath?	25 No	
/ita	icien: Th certificate rector, pag	Be (25. Was case referred to medical examiner?	-							of Death	(Check on	ly one)			,	
of V	is is	2	1 Yes 2 No	Ho	spital:	Inpatient 2	☐ ER/Outpatier	and the second second second	Oth Oth	er: 4 Nu	rsing Hom	e 5□R	esidence	6 □Othe	er (Specify	y)	
ם		on:	27. Manner of Death Natural 5 ☐ Pendii	ng		e of Injury Inth, Day Year)	28b. Time o Injury	f 2	8c. Injun Worl	k?		3d. Descril	be how in	jury occurre	ed		
Sio	Attending r death. ector: After by the fune	catl	2 ☐ Accident invest	igation				М	1 🗆	Yes 2							
Division	si or Attend after death f Director: / d in by the f	Certification;	3 Suicide 6 Could 4 Homicide determ		28e. Plac	ce of Injury - At ding, etc. (Spe	home, farm, sti cify)	eet, factor	, office		28		n (Street i Town, Sta		er or Rura	/ Route Numb	ier,
	To the Hospitei or At within 24 hours after of To the Funeref Direct completely filled in by										1						
	e Hospitei 24 hours e Funerei etely filled	edical	(Check only 2 Medical	ng Physic Examine	r: On the	ne best of my k basis of exami	nowledge, deat nation and/or in	h occurred vestigation	at the tin , in my or	ne, date an pinion, dea	id place, ar ith occurred	nd due to t d at the tin	he cause ne, date a	(s) and mai nd place, a	nner as st ind due to	tated. the cause(s)	
	To the within 2 To the complet	Med	one) 29b. Signature and title of gertifie		and ma	inner stated.		290	License	e number			29d F	ate signed	I (Month	Day Vaarl	
	To To		255. Signature and title or define	,)		an			_		2 0		230.0	.a.c aigned	_ 1	- up, 10d1)	
,			1			・ソン			から	17:	55)	0/1	910	2	
			30. Name and a dress of person Dr. Frederick			use of death (It 6602 Ch			# 1± 1	200 01	neete.	rtarm	МТ	2162	Ω		
			31. Date filed (Month, Day, Year,			Registrar's Sig		IVC	- 11 2	-00 01	.co.e.	- COMI	, 1110	2102		-	
	Sta Registr		QCT 20		No.		& do	who									

•	•	1	For Stata Registrar	State	of Marylan	•	rtment of H		Mental Hygio	200	5 :	35592
	0		Decedent's Name (First, Middle	, Last)					2. Date of Death	· · · · · · · · · · · · · · · · · · ·		3. Time of Death
	Physicia		Peter H	ooper Mas	sk				October	Day 27. 20	Year 005	7:15 A. M
	/Medic Examin		4a. Facility Name (If not institution				4b. City, Town, o	r Location of Death		4c. County		71.45
Mineral P	Examin	51	12730 Bradbury	Ave.			Smiths	burg		Washi	ingto	n
`	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	(earl	9. Birthp.	lace (State or Foreign
	Director		199-32-1522	1 X M 2 □ F	62	Yrs.	Months Days	Hours Will.	Dec. 13,1	942	Penns	sylvania
	D D	-	Usual Residence of Decedent		10. 0	S - 1					-	Od. Inside City Limits
	try far		10a. State 10b. County		100.01	ty, Town or Loc						1 ☐ Yes 2X☐ No
	e Ma Sa-f s	cto		nington		Smit	hsburg					
	15 P	Director	10e. Street and Number	_			10f. Zip Code	700	10	g. Citizen of V		лгу?
	filed within 72 hours after death with the Maryland Hygiene. Hygiene. Ather than "natural", or items 23e or 28e-f show ant, the than "natural" or items 23e or 28e-f show ant, the Maryleal Evantine must be notified at		12730 Bradbury			- [.783			S.A e - Americ	an Indian
	tems rems	Funerai	11. Marital Status	Armed F		.S. 13. V	Vas Decedent of F Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puert	o Rican, etc.)		k, White,	
30	s afte	by F	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 🎛 Divorced	lf Yes, G Year or I	2 🗌 No live Dates:	1	☐ Yes XXNo	Specify:		Specify	<i>'</i> :	White
215-0036	hour tural		15. Decedent		Dates.	16a Deced	ent's Usual Occup	pation	1	6b. Kind of Bu	usiness/Inc	dustry
ç	n 72	Completed	(Specify only highes	t grade completed,		(Give	kind of work done	during most of work	king			
72	withi ene. than	mc	Elementary/Secondary (0-12)	College 4	(1-4or 5+)		Auditor	•			I.F	R.S
2	filed Hygi other ent, I	a)	17. Father's Name (First, Middle,	Last)				18. Mother's Nan	ne (First, Middle, M	aiden Suman	16)	
<u>a</u>	ld be ental ked ic ev	To B	John Q. Masl	k Jr.				Ru	th Hooper			
Maryland 21	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. and Mental Hygiene. is marked other than "natural", or thems 23a or 28a-1 show aumatic event, the Martical Evantime must be notified at	-	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailin	g Address (Street	and Number or Ru	ral Route Number,	City or Town,	State, Zip	Code)
Š	Ith a		John Q. Mask II	ľ		29 N.	Custer A	Ave. New	Holland, P	a. 175	57	
ō,	s 1 ar i Hea item othe		20a. Method of Disposition			Place of Dispo	sition (Name of natory or other pla	ce) Oct.	Date 2	Oc. Location -	City or To	wn, State
9	ages ant of nt: If i		1 Magazial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		n State		g Cemete	0000	•	Smiths	burg,	,Md.
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		21. Signature of Funeral Service		M014	14 22	. Name and Addre	ess of Facility	125	25 Bra	dbury	y Ave.
ä	Dep Per Sun y Pe		+ To Bear	La Da	wis	J.	L. Davis	Funeral	Home Smi	thsbur	g,Md.	21783
	111 357		23a. Part1. Enter the disease, or	complications that	caused the dear							Approximate Interval Between
			shock, or heart failure. List Immediate Cause (Final		dacir iirid.	11.		1: 1 T.	f1	000	,	Onset and Death
	Pnysician /Medical-		disease or condition resulting in death)	a Due to	o (or as a consec	guence of	5 6 61 61	ICAL IVI	farct	UN	5.7	ne hour
	Examiner			A-	Herro	sclei	otic	Cordin	vascul	ar d	isars	e 10 years
	\$-	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	o (or as a consec	quence of):					72.5	7
ti-	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events	С.								
ó	an an rial-tr	Ex	resulting in death) Last	Due to	o (or as a consec	quence of):						
8760,	ate be executed hysician and the burial-transit	dicai		d							_	
9	tifica ng ph as th	Med	IS SELVALE.	T.					112-11		- 0	1
Вох	death certifice e attending ph id for use as th	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant		utcome of pregn		Ectopic pregnanc	y			te of delive	ery Day Year
	0 8 9	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Preg 9□Unk	gnant at time of o		Other (specify) _			IVIC	1101	Day real
O.	at the by the	hys	9 Unknown									
S,	requires that the een signed by th hould be detache	by F	Part II. Other significant condition	.au	death but not re	sulting in the u	nderlying cause gr	ven in Part I.				he cause of death?
rd	en si ould	peq	layper Te	-nsion					1 🗆 Ye	2 No	3 Prob	oably 4 □Unknown
of Vital Record	as as co	pie	Hyperlipio	lemia					24a. Was an autopsy		prior to cor	ppsy findings available impletion of cause of
æ	9 4 9	E O	Diabete	e Mol	litus	-11			perform 1 ☐ Yes 2	ed? ZHO	death? 1 □ Yes	2 🗆 No
ita	ician: Th certificate rector, pag	a	25. Was case referred to medica					26. Place of Dea	th (Check only one)		
>		To B	examiner?	Hospital: 1	Inpatient 2	ER/Outpatier	it 3□ DOA Ott	her: 4 \sum Nursing H	lome Spesider	nce 6 Oth	er (Specif	у)
	ig Ph ter th seral		27. Manner of Death 1 ★ Natural 5 □ Pendir	(AAc	e of Injury onth, Day Year)	28b. Time of Injury	i 28c. Inju Wo	ry at rk?	28d. Describe ho	v injury occur	red	
Division	Attending r death. ector: After by the fune	atic	2 ☐ Accident invest	gation			M 1]Yes 2□No				
<u> </u>	Il or Attend after death Director: / d in by the f	tific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	sined 200. Flat	ce of Injury - At I	nome, farm, str	eet, factory, office		28f. Location (Str. City or Town,		ner or Rura	al Route Number,
	talours after al Dip	Certification:										
	Hospital	edical	29a. Certifier 1/2 Certifyii	ng Physician: To the Examiner: On the	he best of my kn basis of examin	owledge, deat ation and/or in	h occurred at the ti	ime, date and place	e, and due to the ca erred at the time, da	use(s) and ma te and place.	anner as st	tated. o the cause(s)
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.		one)	and ma	anner stated.							
	To the I within 2 To the I complet	Σ	29b. Signature and title of certifie	1 W/		0	29c. Licen	se number	29	d. Date signe	u (Month,	Oct - 2-
)			/ Morge	C 1ke	man	M.	DOC	11/57	1 6	CTO	her	20,2005
	10		30. Name and address of person	who completed ca	use of death (Ite	23a) (Type,	Print)	n	0 11	,	,,,	D 2171/2
	4		7	UMAN Ir	1/110	> Meg	ILal Cal	mpus Ko	ad Hage	1510WN	17	V 21242
÷-		ate	31. Date filed (Month, Day, Year	2005	Hegistrar's Sign	nature						28,2005 D 21242
	Regist	rar	NOV 0 3	LUUJ MAN	E Charles .	- 6						

		1	For State Registrar		State of	Marylan		artment <i>rtificate</i>			and M	lental Hy	giene Reg. No.	005)	35593
			1. Decedent's Name (First, Midd	le, Last)								2. Date of De Month	ath Day		ear	3. Time of Death
	Physicia /Medic		Lola	Eliz	abeth	Morgan						Octobe				12:00 P M
	Examin	.2	4a. Facility Name (If not institutio	n, give str	eet and nun	nber)		4b. City, T	own, or	Location	of Death			County of		
	- ×	1	St. Mary's Hos			- 4		Leona If Under 1		own If Under	24 Ure	a Data of Bio		. Ma		
	Funeral		5. Social Security Number	6. Sex	/ 2 万 F	7. Age (In yrs.	<i>73</i> Yrs.		Days	Hours	Min.	8. Date of Bir (Month, Da September			Cour	
	Director	-	215-36-3472 Usual Residence of Decedent									Берсешье	, .	732	nary.	Lanu
	/land		10a. State 10b. County	1		10c. Cit	ty, Town or Lo	cation							1	0d. Inside City Limits
	Many 3-1 sh	tor	Maryland St. Ma	ary's		Mec	hanicsv	i11e								1 ☐ Yes 2 No
	th the	Director	10e. Street and Number					10f. Zip (Code				10g. Citiz	en of Wh	at Cour	ntry?
	1h wil		27045 Three Notch					20659					US			
	r dea	Funeral	11. Marital Status		Armed For		.S. 13.	Was Decede If Yes, specif	ent of Hi fy Cuba	spanic Ori n, Mexicar	gin? (Sp 1, Puerto	ecify Yes or No Rican, etc.)	- 1		Americ White,	an Indian, etc.
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Mai 3 ☑ Widowed 4 ☐ Divorce		1 ☐ Yes If Yes, Giv	9		1 ☐ Yes 2	∏ No	Specify:				Specify:	White	
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. od other then "natural", or items 23e or 28e-f show adont, the Medical Exam for must be notified at	q pe	15. Decede		Year or Da	ates.	16a. Dece	dent's Usual	Occupa	ation			16b. Kin	d of Busi		
5	in 72	Completed	(Specify only highe		completed)	45-1	(Give	kind of work DO NOT use	done a	luring mos	t of work	ing				,
12	filed within Hygiene. other then "	mo	Elementary/Secondary (0-12) 7		College (1	-40r 5+)	Home	emaker					Own	Home		
D	illed Hygid othar ant, Il	Bec	17. Father's Name (First, Middle,	Last)		-				18. Mothe	er's Nam	e (First, Middle	Maiden S	Sumame)		
<u>lar</u>	Aental Aental rked c	ToB	John Louis Tippet	t						Mary	Etor	1e Hayder	1			
Maryland	2 should be 1 n and Mental I is marked o raumatic ava		19a. Informant's Name/Relation	ship (Type	e, Print)		19b. Maili	ng Address ((Street a	and Numb	er or Run	al Route Numb	er, City or	Town, St	ate, Zîp	Code)
	is 1 and 2 should by Health and Men itam 27 is marke other traumatic	10.	Patricia A. Downs	/ Nie	ce					chanic		e, Maryla				
ore	a 0 = =	3	20a. Method of Disposition 1 Burial 2 Cremation	з ПВе	moval from	a	Place of Dispo cemetery, createn of Po	matory or oth	e of her plac	θ)		ober	20c. Loc	ation - Ci	ity or To	own, State
<u>Ĕ</u>	Pages ment of ant: If it ury or o		`4 □Donation 5 □ Other (Specify)		Que	Cemet				26,	2005	He1en	Mary	1ano	
Baltimore,	permit. Pag Department Important: I any injury o		21. Signa are of Funeral Service	Licensee	Ma	dine (/ Ma	2. Name and attingle .O. Box	ey-Ga	ardine	r Fun	eral Home wn, Maryl	, P.A and 2	0650		
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complic	tions that c	aused the sea										Approximate Interval Between
	Physician		Immediate Cause (Final	it offig offe		-diac	and	withou	nic	2						Onset and Death
	/Medical		disease or condition resulting in death)	_ a.		(or as a consec	quence of):	1		i						1000
6	Examiner		O CONTROL DATE OF STREET	b.	m	100000) cal	inf	ar	cha	n					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	•	⊃ua t√	or as a consec	quence of):	.(Ω						
	cutec nd rransi	Examin	Cause (Disease or injury that initiated events	c.		roncur	y a	rten	5_	0180	in	-				
Ő,	e exe		resulting in death) Last		Due to	or as a consec	quence of):	-								
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Medical		d.												
9	leath certifica attending ph I for use as the	/Med	IF FEMALE:	22	o If was out	come of pregn	ancy	· · · · · · · · · · · · · · · · · · ·		- 10				3d. Date	of dollar	
Вох	ath c	lan	23b. Was decedent pregnant in the past 12 months?	23	1 Live b	oirth 2 Feta	al death 3[☐Ectopic pre☐Other (spe					2	Month		Day Year
	the a	ysic	1 ☐ Yes 2 ☒️No 9 ☐ Unknown		9□ Unkn		Jean 5	_ Other (spe	эсну)							
P.0.	that the death led by the atter detached for i	Ph	Part II. Other significant condit	ions cont	ribjūting/to di	eath but not res	sulting in the t	ınderlying ca	use givi	en in Part	l.	23e. Did	obacco us	se contrib	ute to t	he cause of death?
ds,	signed by	d by	Diabetes 1	ne	ditus	, Supe	. U					10	Yes 25	21№o 3	☐ Prob	ably 4 Unknown
of Vital Records,	w requir been si should l	Completed	Done (100.	PEC.	enci	Anon	m/c 1	H.	2010	08	24a. Was	an	24b. We	ere auto	ppsy findings available
Re	ne lav s has ge 2	dm	Dance	<u> </u>	77.00	0	1 11 00	1		dise	ne		ormed?	de	ath?	impletion of cause of
a			25. Was case referred to medic	al						26 Place	e of Deat	1 ☐ Yes	2 No	1] Yes	2/2 No
⋚		To Be	examiner? 1 Yes 2 No		spital:	Inpatient 2 🗵	ER/Outpatie	nt 3 🗆 DO/	A Oth	or		me 5 Resi		Other	(Specia	٧)
of	g Phys er this eral di	n: T	27. Manner of Death			of Injury th, Day Year)	28b. Time o		Bc. Injun			28d. Describe				.,
ion	nding ath. r: Afte e fun	atlo	1 Natural 5 ☐ Pend 2 ☐ Accident inves	ing tigation	(IVIOII)	ui, Day reai)	Injury	М		Yes 2	No					
Division	To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification:	3 Suicide 6 Could deter	not be mined	28e. Place buildi	of Injury - At h	nome, farm, st ify)	reet, factory,	, office			28f. Location (City or To	Street and wn, State)	l Number	or Rur	al Route Number,
	urs al	Ce	20a Cantilla	ina Direct	oine: T: "	hoot of coult	outodas 1	the management of	ne eb = **	no dat-	nd plans	and due to the	021122/2	and mar-	10f 22	tated
	Host 24 ho Fune rtely fi	ledical	29a. Certifier 1 Certify (Check only 2 Medics	ing Physi il Examin	er: On the b	e best of my kn asis of examin ner stated.	owledge, dea ation and/or in	in occurred a nvestigation,	in my o	ne, date ar pinion, dea	ath occur	and due to the red at the time,	date and	ano manr place, an	d due t	o the cause(s)
	tha ithin i	Mec	29b. Signature and title of certif	ier			^-	29c.	License	e number			29d. Date	signed (Month,	Day, Year)
	F ≱ F 8	-	162		IV		M	. 9.	D	51	7:	38	10	24	4.2	005
7	ca		30. Name and address of perso	n who cor	npleted caus	se of death (Ite	m 23a) (Tvne	. Print)		-			, ,		~	1-220121
-	h N'		KAE T. AU	MG,	24	435 1	MERV	ELL	D)BAN	R	D. Ho	LLY	WOC	0	m) 2063(
1 2	St Regist	ate rar	31. Date filed (Month, Day, Yea OCT 2	5 20	05 32.	egistrar's Sign	ature	hodi	,							

Amend internation of Perantinent of Health and Mental Hygiene 05 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Dav Year **ESTHER** MOLENOF OCTOBER 2005 12, 3:15P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2X F Months Director -56-9867 104 JUNE 21 1901 MARYLAND Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 27 is marked other then "neturel", or items 23a or 28e-f show traumatic event, the Modical Examinar must be notified at 1 X Yes 2 No Director MARYLAND MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 6121 MONTROSE ROAD 20852 UNITED STATES OF AMERICA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel; or iten ery Injury or other traumatic event, Ire Medical Examinations. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: WHITE Specify: 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ABRAHAM GOODMAN SARAH POTTS ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2826 CAMERON WAY, FREDERICK, MD 21701 ALBERT O. MOLENOF - SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) MT. LEBANON CEMETERY 10/16/05 ADELPHI, MARYLAND 21. Signature of Funeral Service License DANZANSKY GOLDBERG MEMORIAL CHAPEL, INC. Donald (1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Atheroscleretic heart /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and I-transit The law requires that the death certificate be executed Due to (or as a consequence of) attending physician a for use as the burial-Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Y 021 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 2 🗆 No 1 ☐ Yes 2 No 1 🔲 Yes Division of Vital Hospital or Attending Physicien: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient Other: 4 - Jursing Home 5 - Residence 6 - Other (Specify) ٩ 1 Yes 2 70 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After Injury s after dec. 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide filled in within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Will 55252 m D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hockville, mo 20852 Wilks, Road 13. UN. D. 6121 Montrose 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiege 0 0 5 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 27, 2005 OCTOBER **Physician** 11:15P. м Blair Armstrong McNinch /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE 36 OLD FORGE LANE PERRY HALL If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Aug. 31, 1978 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 27 220-04-0912 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits irel', or items 23a or 28a-f show Examiner must be notified at X□Yes 2□No Perry Hall Director Baltimore Maryland the 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? America United States of 21128 36 Old Forge Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □XYes 2 □ No If Yes, Give 1

Never Married 2

Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Completed by Specify: Caucasian 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "neturel" other than "netu 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Automobile Elementary/Secondary (0-12) College (1-4or 5+) Hygiena. 12 Driver Dealership 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental is marked Eugene Robinson McNinch Jr. ဥ Paula Elise Knight 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 60048 19a. Informant's Name/Relationship (Type, Print) Father 201 E.Cook Ave., Apt.413, Libertyville, Ill. Health item 27 i Dr. Eugene McNinch 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Lakeside Cemetery 10/31/05 Dover, Delaware permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility Home, P.A. 21629
Moore Funeral Home, P.A. Denton, Maryland
12 South Second Street, Denton, Maryland 21. Signature of Funeral Service Licenses look 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) contact guishot wound to have **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 Fetal death ģ in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown cate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 2 No 1 ☐ Yes 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of ath?

1 Yes 2 \(\subseteq \) No 24a. Was an autopsy performed? this cartificate Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one | Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE ို Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred subject short 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After Brund 7:12 PM 5 Pending 1 Natural 5eH 1 ☐ Yes 2 No death. investigation 10/27/05 after death the 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 36 Olde Forge Larne filled in by Homicide some 24 hours 29a, Certifie Medical and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number OCME OCTOBER 28,2005 who completed cause of death (Item 23a) (Type, Print) 111 Penn Street 30. Name and address of person Baltimore, Maryland 21201 Pamela . Southerly MD

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Régistrar's Signature

2005

			For State Registrar	State of Ma	rylan	d / Depa <i>Ce</i> a	artment o	f Health and of Death	d Mental Hyg	gierje () Reg. No.	05	35596
	9		1. Decedent's Name (First, Middle, Last)					2. Date of Dea		Vana	3. Time of Death
1	Physici /Medi	-	Theodore	Rooseve	lt	Manlo	ve		Octobei	23 Day	2005	7:30 A
	Examir		4a. Facility Name (If not institution, give				1	n, or Location of De	eath	4c. Co	unty of Death	
		.,	Caroline Nursir	g Home,	Inc		Der	nton		Ca	arolin	ie
	Funeral	2	Social Security Number 6. Se	x 7. Age ⊒M 2□F	(In yrs.	last birthday)	If Under 1 Ye Months Da		lin. 8. Date of Birt (Month, Date July 5	h v. Year)	_ Cou	place (State or Foreig ntry)
1460	Director		221-05-2592	2 141 2 1	86	Yrs.			July 5	, 1919	Del	aware
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits
	Manyi f eho	ō	Manual and Como	line		Dento	'n					1 ☐ Yes 2 N
	the t	rect	Maryland Carc	TINE		Dence	10f. Zip Cod	de		10g. Citizen	of What Cou	ntry? Americ
	With 3a or		901 South Secon	d Stroot			21	629			State	TIMELIC
	hours after death with the Maryland turat, or tiems 23s or 28s-f show at Examirer towast be inclifted at	Funeral Director	11. Marital Status	12. Was Decedent E		.S. 13.			(Specify Yes or No- rerto Rican, etc.)		Race - Ameri	can Indian,
9	after o	Für	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give	。19	41 →	_		ierto Hican, etc.)		Black, White,	etc.
21215-0036	rat', c	by	3 Widowed 4 Divorced	Year or Dates:	19	45	1□Yes 2🔀	No Specify:		Sp	ecify: Cauc	casian
5-0	72 ho	Completed	15. Decedent's Ed (Specify only highest grad			(Give	dent's Usual Oc	one during most of	workina	16b. Kind	of Business/In	ndustry
2	within ene. then	npic	Elementary/Secondary (0-12)	College (1-4or 5-	+)	`life.	DO NOT use re	etired)		Aut	qque o	ly Store
	ygier ygier ner t≱		12				Manage		(7)			
ng Pu	be first H	Be	17. Father's Name (First, Middle, Last)					18. Mother's	Name (First, Middle,	Maiden Sui	тате)	
Maryland	12 should be filed within in and Mental Hygiene. 7 is marked other than "reumatic event, the Mac	2		Manlove		105 14-77			na Mackl			0.11.2.2.2.2
Na Na	12 st h and 7 ts n traum		19a. Informant's Name/Relationship (7		c _							^{Code)} 21629
	is 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examilier is ust be inclified at		Mary S. Manlos 20a. Method of Disposition	re Wii	_		SOUTH Osition (Name o		Street,		on, M	
Ö	nt of l		1 Surial 2 ☐ Cremation 3 ☐		0	emetery, cre	matory or other	place)			,	
Baltimore,	t. Pag rtment rtant: I		`4 □Donation 5 □ Other (Specify		Co			cery [10]	27/2005	Conc	ord,	Maryland
Bal	permit. Pages Department of Important: If I eny injury or one		21. Signature of Funeral Service Ligan:	n-ne					Home, P	.A.		21629 Maryland
to the	Ţ,		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	lications that caused one cause on each lin	the deat	h. Do noten	ter the mode of	dying, such as care	nd Stree	t, De	enton,	Maryland Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a Due to (or as a			mer	1113				yrs
	Examiner			Due to (or as a	a conseq	dence or):						
	*	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	a conseq	uence of):						
	uted	m m	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events									
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9	tificate ig phys as the	ledi		<u> </u>								
Вох	death certific e attending pl id for use as t	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at	2 Feta	I death 3	□Ectopic pregna □ Other (specify			23d	. Date of deliv Month	rery Day Year
0	t the by th ache	hys	9 Unknown	9□ Unknown								
Q.		y P	Part If. Other significant conditions co	entributing to death bu	it not res	ulting in the u	underlying cause	e given in Part I.	23e. Did t	obacco use	contribute to t	the cause of death?
Ę	= ° 0	pa							_ 1□`	res 2 💢	lo 3□Pro	bably 4 Unknow
ပ္တ	2 0 5	Completed							24a. Was	an 2	4b. Were auto	opsy findings available
R	0 5 6	E							autor perfo 1 ☐ Yes	rmed?	death?	
ta	i cien : Th certificate rector, pag	0	25. Was case referred to medical					26. Place of	Death (Check only of		103	20110
Į V	X = 5	To B	examiner?	Hospital: 1 ☐ Inpatie	nt 2 🗆	ER/Outpatie	nt 3□ DOA		ng Home 5 Resid		Other (Speci	ify)
0			27. Manner of Death	28a. Date of Injur (Month, Day	y (Year)	28b. Time o	of 28c.	Injury at Work?	28d. Describe			·····
Ö	Attending in death. ector: After by the fune	atic	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		, , , ,	,,		1 Yes 2 No				
Division of Vital Records,		Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju- building, etc	ry - At h	ome, farm, st	reet, factory, of	fice	28f. Location (: City or Tox		umber or Rur	al Route Number,
Q	itel or irs afte rel Dir led in											
	e Hospitel of 24 hours at e Funerel Dietely filled i	edical	(Check only 2 Medical Exam	sician: To the best of tiner: On the basis of	examina	owledge, dea ation and/or in	th occurred at the	he time, date and p my opinion, death o	ace, and due to the occurred at the time.	cause(s) an	d manner as :	stated. to the cause(s)
	To the Hos within 24 hor To the Fun completely	Medi	one)	and manner sta	ted.							
	To To	1	29b. Signature and title of certifier	NL'		110		cense number 004753	1.		igned (Month, 24/c.E	
				777		MI		.04,03	7	.01	7105	>
-		1	30. Name and address of person who	completed cause of de	eath (Iter	п 23а) (Туре	, Print)					

DHMH 17 Rev 1/2001

State Registrar

Wafik Zaki, M.D.
31. Date filed (Month, Day, Year)
001 2 5 2005

920 Market Street, Denton, Maryland 21629

			State of Maryland / Department of Health an 1- State Registrar Certificate of Death	nd Mental Hygiet Reg.	
	Physicia		1. Decedent's Name (First, Middle, Last) Alice Wynee Miles	2. Date of Death Month October	Day Year 3. Time of Death 3:30 A M
>	/Medic Examin		4a. Facility Name (If not institution, give street and number) 10493 Mark Drive 4b. City, Town, or Location of C	Death	4c. County of Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	Hrs. 9 Date of Birth	Charles 9. Birthplace (State or Foreign Country)
	Director		577-80-3475 1 M 2 M 2 M 45 Yrs. Months Days Hours 1	Min. Oct.8,19	60 Wash., D.C.
	Aaryland show	ō	10a. State 10b. County 10c. City, Town or Location Waldorf		10d. Inside City Limits 1 ☐ Yes 2 【XNo
	or 28a-	Directo	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Country?
	death v	Funerai	10493 Mark Drive 20601 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, Personal Process.	n? (Specify Yes or No-	USa 14. Race - American Indian, Black, White, etc.
920	be filed within 72 hours after death with the Maryland and Hygiene. d other than "natural", or items 23a or 28a-f show a other than "natural", or items 23a or 28a-f show event, the Madical Examiner count be notified at	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give \(\hbar{\text{M}} \) 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	delle Houri, deci,	Specify: Black
15-0	n 72 ho "natur	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	f working	epartment of
1212	a filed within all Hygiene. other than "		Elementary/Secondary (0-12) 12 College (1-4or 5+) Administrative A		griculture
ıland	ould ba fii Mental H arked oti atic ever	To Be	17. Father's Name (First, Middle, Last) William C. Walls, Sr. Ruti		Easton
Maryland 21215-0036	S DE E		19a. Informant's Name/Relationship (Type, Print) Gwendolyn R. Morris/sis. 19b. Mailing Address (Street and Number of Sundolland Dr		ity or Town, State, Zip Code) 11, MD 20745
ore,	permit. Pages 1 and 2 Department of Health a Important: if Item 27 is any injury or other tra		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition (Name of cemetery, crematory or other place)		Location - City or Town, State
Baltimore,	permit. Pa Departmen Important: any injury once.		Apost.FaithChr.Cem. 1 21. Signature of Funeral Service Licensee 22. Name and Address of Facility		randywine, MD neral Home ince Fred.,MD2067
8	89 5 5 8		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca		Approximate
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition AMETASTATIC COLON CANCER	,,	Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):		
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
90,	cate be executad ohysician and tha burial-transit		that initiated events c		
68760,	ntificate ng physi as tha b	Medicai	d.		
Box	requires that the death certifics lean signed by the attending ph hould be detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		23d. Date of delivery Month Day Year
, P.O	res that the de igned by the a be detached i	by Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
Records,	v require bean sig should b				2 PNo 3 Probably 4 Unknown
Rec	has has	Completed		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 Pa No
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of		-	27. Manner & Death 28a. Date of Injury 28b. Time of 28c. Injury at 1. [PMatural 5 Pending (Month, Day Year) Injury Work?	28d. Describe how in	
Division	ten leati tor: the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		t and Number or Rural Route Number, tate)
	To the Hospital or Attend within 24 hours after death To the Funeral Diractor: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and p	place, and due to the cause	e(s) and manner as stated.
	To the Ho within 24. To the Fu completel	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated. 29b. Signature and title of certifier 29c. License number		and place, and due to the cause(s) Date signed (Month, Day, Year)
	ë 4 € 4		1 Jega 0 8 no D59942	2	10/12/05
	Ω		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		
	(2)		DEEPNARAYAN TIWARRI, MD 8926 WOODYARD Rd, #20	1 CLINTON A	up 20735

KYLE R. MORSELL 05-06804 RKD

	_		For State Registrar	State of Ma	ryland /	Depa <i>Cer</i>	rtment	of H	ealth a Death		F	leg. No.			355	
	Physicia	an	1. Decedent's Name (First, Middle, Last)	D M	1 1						2. Date of Dea Month OCTOBER	th Day	' no Ye	ar 3	3. Time of D	
	/Medic		Ky1e		rsell		41. 01. 3	-			OCTOBEL		, 2005 County of D		3:23A.	. M
	Examin	er	4a. Facility Name (If not institution, give s 2509 SANSBURY ROAD					R MA	Location of RLBOR	RO	PRINCE G			SEORG		
	Funeral Director		212 /0 1/11 /1	M 2□F	31	Yrs.	Months	Days	Hours	Min. A	8. Date of Birth (Month, Day ug. 16	, Year)	74 Ma	Country)	e (State or I and	Foreign
	ath with the Maryland 23a or 28a-f show ust be notified at	ctor	Usual Residence of Decedent 10a. State 10b. County Pri Maryland Georg	nce e's	10c. City, To	own or Loc		рре	r Ma	r1bo	ro				Inside City	**
	h with th 23a or 26 at be no	Funeral Director	10e. Street and Number 2509 Sansbury	Road			10f. Zip		2077	4		10g. Citi	izen of What USA	-	?	
920	after dez or itams	þ	11. Marital Status ¹∏ Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		- 1	Vas Deced Yes, spec		spanic Orig n, Mexican, Specify:	jin? (Spec Puerto R	cify Yes or No- lican, etc.)		14. Race - A Black, V Specify:	/hite, etc.		
21215-0036		Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5		(Give i life. [ent's Usua kind of wor DO NOT us Stud	k done d e retired)	uring most	of working	g		ind of Busine		try	
land 2	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any follury or other treumatic event, Italia pages.	To Be Co	14 17. Father's Name (First, Middle, Last) Pinkney	4	Morse		Scuu	ent		rs Name	(First, Middle,		Sumame)	ige	s	
Maryland	id 2 shou th and M 27 is mar treumat		19a. Informant's Name/Relationship (Type Pinkney Morsell		1		-				Route Numbe	-				7 4
	iges 1 an of Heel or other		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R.		20b. Place ceme	of Dispos tery, crem	sition (Nam	ne of ther place	9)	Da	nte	20c. Lo	cation - City	or Town,	, State	
Baltimore,	permit. Pa Departmen Important any injury once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Rd. Prince Fred., MD 206 23a. Partt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate													
,	Physician /Medical		23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused e cause on each lin Intra- Due to (or as	oral	gun.			, such as o	1	respiratory ari	rest,		Int	proximate terval Betweenset and De	en eath
8760,	vsicien and www.	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last b. Cue to (or as a consequence of): Due to (or as a consequence of):													
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	w requires that the been signed by th should be detache	Ď	Part II. Other significant conditions con	tributing to death bu	ut not resulting	g in the ur	nderlying ca	ause give	n in Part I.			es 2	se contribut No 3□		ause of dea y 4 ⊟Un	
Division of Vital Records,	The law ete hes b page 2 si	Completed								_	24a. Was a autop perfor 1 X Yes	sy med?	prior	to compli	findings avertion of cau	/ailable use of
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?					Lou			(Check only or					
_	Physician: r this certific ral director,	유	IXI Yes 2 No		nt 2 ER/				4 🗆 1401		e 5 🗆 Resid			Specify) S	CENE	
sion (Attanding F r death. actor: After by the funer	ation	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	Year)	Time of Injury	AM 21	8c. Injury Work	at ? ′es 2⊠N		8d. Describe h	1	hot hot	him	t) sec	2
Divi	rs after de si Diract	Certification;	3 Suicide 6 □ Could not be 4 □ Homicide determined	28e. Place of Injubulding, etc	iry - At home, :. (Specify)	farm, stre	et, factory her				8f. Location (S City or Tow	n, State	12509	San:	sbury	r, Rd
	To the Hospital or Attending Physicien: To the Tuneral Bifschoath. To the Funeral Director Affer this certific completely filled in by the funeral director.	edicai	29a. Centifier (Check only one) 1 Certifying Physical Exemination (Check only one)	icien: To the best of er: On the basis of and manner sta	examination	lge, death and/or inv	occurred a restigation,	at the tim in my op	e, date and inion, deat	place, ar	nd due to the d	ause(s)	and manne	as state	d. e cause(s)	
	To the To the comp	Me	29b. Signature and title of certifier	いつ				. License					e signed (M			
			30. Name and address of person who co	_	eath (Item 22	a) (Tuna I		o.c.	м.Е.			CTO	BER 6,	2005)	
	6		LING LI,	MID	·		111 p	ENN	STREE	T BA	LTIMORE	E, MA	RYLANI	212	201	
	Sta Registr		31. Date filed (Month, Day Year)	32. Registr	rs Signature	J.	door	Ro								

			For State Registrar	State	of Maryland		artment of H		nd Mental Hy	giene	005	35599
			Decedent's Name (First, Middle	ə, Last)					2. Date of De Month	ath Day	Year	3. Time of Death
	Physici: /Medic		Mildred Anna	Mattis	on				Octobe:	r 2,	2005	4:35 P. M
	Examin		4a. Facility Name (If not institution	-			4b. City, Town, or		Death		County of Dea	ath
			11450 Asbury Ci			- A E (- A E - A A)	Solomons If Under 1 Year	If Under 24	Hrs. 8. Date of Birt		alvert	rthplace (State or Foreign
	Funeral Director		5. Social Security Number $064-01-7128$	6. Sex 1□ M ★ F	7. Age (In yrs. Ia 92	Yrs.	Months Days		Min. (Month, Da	7, Year)	1912	Pennsylvania
			Usual Residence of Decedent	21						,		
	nyland how		10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	88-1-19	cto	Maryland Calve	rt	Solo	mons	1			10 - 011	zen of What C	
	a or 2	Dire	10e. Street and Number	mala #42	2		10f. Zip Code 20688			•	ted Sta	,
	4 within 72 hours after death with the Maryland Jiene. r than "natural", or Items 23a or 28a-f show the Medical Exactinat must be routhed at	Funeral Director	11450 Asbury Ci	12. Was De	ecedent Ever in U.S	13.	Mas Decedent of Hi	ispanic Origii	n? (Specify Yes or No		14. Race - Am	erican Indian,
(0	r Item	문	1 Never Married 2 Mar	ried 1 ☐ Ye	Forces? s 2 X No	'	f Yes, sp <i>eci</i> fy Cuba	n, Mexican, I	Puerto Rican, etc.)		Black, Wh	ite, etc.
036	ral', o	þ	3 Widowed 4 □ Divorced	If Yes, or Year or	Dates:		1 ☐ Yes 2X☐ No	Specify:			Specify: W	nite
5-0	72 hc 'natu	Completed	15. Deceder (Specify onfy highe	t's Education st grade complete	d)	(Give	lent's Usual Occupa kind of work done of DO NOT use retired	during most o	of working	16b. Ki	nd of Busines	s/industry
121	within ene. than *	ldm	Elementary/Secondary (0-12)		2 (1-4or 5+)		ewife	"		Hom	emaker	
2	Hyg The		17. Father's Name (First, Middle,			HOUS	EMTIE	18. Mother's	s Name (First, Middle,			
an	be data be	To Be	Walter Noble					Mabe:	l Herron			
Maryland 21215-0036	2 shoul and Ma Is mari	-	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailir	ng Address (Street a	and Number	or Rural Route Numbe	er, City o	r Town, State,	Zip Code)
	rt 2 mg		Richard S. Matt	ison (So	n)							yland 21114
ore	0 0		20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal fro	m State		sition (Name of matory or other plac		Date		cation - City o	
Baltimore,	Pages ment of tant: If it		' 4 □ Donation 5 □ Other (S	Specify)	Arl			-	. 10/26/05			
3all	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service	Licensee					Rausch Fu Road, Port 1			
	@ □ ≥ # O	\vdash	23a. Part1. Enter the disease, o	r complications tha	it caused the death				-		LIC, MAL	Approximate
	s		shock, or heart failure. Lis	only one cause o	n each line.			3 ,	,			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due	etastati to (or as a consequ		incer					5 months
	Examiner				10 (0. 40 4 60),004	01100 01,1						
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due	to (or as a consequ	ence of):						
	be executed sicien and burial-transit	Examin	inal initiated events	С								
, 0,	e exe sien a urial-i		resulting in death) Last	Due	to (or as a consequ	ence of):						
8760	cate b ohysic the b	dlca		d								
9 x	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE:	23c. If ves.	outcome of pregnar	ncy					23d. Date of d	elivery
Вох	atten for u	clan	23b. Was decedent pregnant in the past 12 months?	1□Liv	e birth 2 Fetal egnant at time of de	death 3]Ectopic pregnancy] Other <i>(specify)</i>	·			Month	Day Year
P.O.	that the de led by the a detached	nysl	1 ☐ Yes 2 2 No 9 ☐ Unknown	9□ Un	known							
	res that igned b	by PI	Part II. Other significant condit	ions contributing to	death but not resu	lting in the u	nderlying cause give	en in Part I.	23e. Did t	obacco ı	ise contribute	to the cause of death?
rds	w require been sig should b								1	Yes 2	X No 3□F	Probably 4 Unknown
Records,	law requase been 2 should	Completed							24a. Was	OSV	prior to	autopsy findings available completion of cause of
Ä	The ate h page	Com							perfo	rmed? 2 No	death? 1 ☐ Ye	es 2 No
Vital	cian: ertific actor,	Be (25. Was case referred to medical examiner?	Heenitel:			Oth		of Death (Check only	опе)		
of	Physician: this certificanal director, it	2	1 ☐ Yes 2 💢 No 27. Manner of Death			ER/Outpatie		er: 4 🗌 Nurs	sing Home 5 Resi	-	6 ⊡Other (Sp v occurred	ecify)
no	Jing After fune	tlon	1 Natural 5 Pend	ng (M	ite of Injury Ionth, Day Year)	Injury	Wor	k?`` Yes 2∐N			, 00001100	
Division	Attending r death.	flca	3 Suicide 6 Could	mot bo	ace of Injury - At hor ilding, etc. (Specify	me, farm, st	reet, factory, office		28f. Location (Street an	d Number or I	Rural Route Number,
Div	after after 1 Dira d in b	Certification:	4 Homicide	bu bu	ilding, etc. (Specify)			City or To	wn, State))	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,								place, and due to the			
	ha Ho in 24 he Fu pletel	edical	one)	and m	anner stated.	ion and/or ir			Toccurred at the time,			
	To t To t com	Σ	29b. Signature and title of certifi		4		29c. Licens			29d. Da	te signed (Moi	nth, Day, Year)
•				Bennet				5150	0	Octo	ber 3,	2005
	22		30. Name and address of person					.a .	aber 16		20653	
	au c	ate	Charles W. Benr 31. Date filed (Month, Day, Yea	LECT, MD	Registra s Signat	ure	uenan koa	ia, Lus	sby, Maryla	TIO .	2065/	
	Regist		l oc.	T - 6 200	Registry's Signat	, J.	Gosta					

Ste	ven McN	lur.	ray	State of Marylan				-	(aio=o = = ==	05000
		•	- State Unpend Item 2					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Reg. No.	35600
	Divisio	(w	1. Decedent's Name (First, Middle, Last)					2. Date of De Month		3. Time of Death
	Physici /Medio Examir	cal	Steven Louis I 4a. Facility Name (If not institution, give s	Mc Murray treet and number)		4b. City, Town,	or Location of Dea	Octobe	er 13, 200 4c. County of	
	.T 12 p		420 Calvert Pines		last histaday		rederick	S. A Date of Bir	Calvert	Birthplane (State or Foreign
2	Funeral Director		5. Social Security Number 6. Sex 15.	M 2□F 46	Yrs.	Months Days				Birthplace (State or Foreign Country)
Š	D		Usual Residence of Decedent		y, Town or L	anation				10d. Inside City Limits
	anylar	5	10a. State 10b. County	Toc. Cit	y, rown or L		- D			1 StYes 2 □ No
	28a-1	rect	MD Calve	rt		10f. Zip Code	e Frede	rick	10g. Citizen of Wha	at Country?
	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show he Medical Evanthar must be notified at	Funeral Director	420 Calvert Pin	es Apt. 113	l	2	0678		US	A
	tems tems	uner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of If Yes, specify Cub	Hispanic Origin? ban, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	0- 14. Race - Black, 1	American Indian, White, etc.
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates:		1 ☐ Yes 2🎇 No	Specify:		Specify:	White
21215-0036	72 hou natura lical E	ted	15. Decedent's Educ (Specify only highest grade	cation	16a. Dece	edent's Usual Occu	pation	vorkina	16b. Kind of Busin	
21	ithin 7 ne. nen "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	ed)			
	Hygier Hygier Sther ti		9 17. Father's Name (First, Middle, Last)		HVAC	Master			Heating Maiden Sumame)	g and Air
lan	should be find Mental had marked of	To Be	Louis Mc Murray					hy Volk		
Maryland	2 shou and M le mar	-	19a. Informant's Name/Relationship (Type		19b. Mail	ing Address (Stree			per, City or Town, Sta	ite, Zip Code)
	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.		Shaun Mc Murray			1 Rando:	lph Blv	d. San	Antonio 20c. Location - Cit	TX 78233
Baltimore,	ages 1 nt of H :: If Ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cemetery, cre	matory or other pla				3 M-908-1 10788433
Ħ	permit. Pa Departmer Important any injury		4 Donation 5 Other (Specify) 21. Signature of Funeral Service License			Pake Cre			Peltsvi	
B	Deparent Important Importa		1 CINION		F	0 Box 4			-Wood F.	
Ξ,	- XA		23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the deat ne cause on each line.						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	Cardiac arrh	ythmia					Onset and Death
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	cuted nd ransit	Examiner	that initiated events	i						
760,	ate be executed nysician and he burial-transit	EX	resulting in death) Last	Due to (or as a conseq	quence of):					
687	tificate b ng physions as the b	edical		1.						
Box (n certificat anding phy use as th	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		□Ectopic pregnand	24		23d. Date of	•
	that the death certifica ed by the attending ph detached for use as th	Completed by Physician/Medi	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of c		Other (specify)	y		Month	Day Year
P.0	requires that the een signed by th hould be detache	Phy	9 ☐ Unknown Part II. Other significant conditions cor	ntributing to death but not res	sulting in the	underlying cause g	ıven in Part I.	23e. Did	tobacco use contribu	ite to the cause of death?
Records,	es Gu	d by				, , ,		1 🗆	Yes 2 □ No 3	Probably 4 LUnknown
Ö		ojete						24a. Was		re autopsy findings available in to completion of cause of
Be	sician: The law certificete has b rector, page 2 s	mo						auto perf 1 X Yes	ormed? dea	th? Tes 2 No
Vital	Physician: this certific ral director.	Be	25. Was case referred to medical examiner?	loopitali.				eath (Check only	one)	
of	Physi r this c ral dire	<u>1</u>	1X Yes 2 No 27, Manner of Death	lospital: 1 Inpatient 2 Inpatient 2 Inpatient 2	ER/Outpatie	SIL SEL DOA			how injury occurred	(Specity)
lon	ath. r: After te funer	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	We	ork? ∐Yes 2∐No			
Division of	or Atta after de Directo in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, s ly)	treet, factory, office)	28f. Location City or To	(Street and Number own, State)	or Rural Route Number,
_	Hospital 14 hours e Funeral I	cal Ce	29a. Certifier 1 Certifying Phy.	sician: To the best of my kno ner: On the basis of examina	owledge, dea	ith occurred at the	time, date and pla	ice, and due to the	cause(s) and mann	er as stated.
	the H hin 24 the F mplete	Medicai	one) 29b. Signature and title of certifier	and manner stated.			nse number	our do at the time	29d. Date signed (I	
	5 <u>1</u> 5 9		200. Signature and title of certines	1			ME			
			30. Name and address of person who co	ompleted dayse of death (ite	m 23a) (Type	o, Print) 111 P	enn Stre	et Balt	October 1 imore, Ma	.4, 2005 ryland 21201
1			THE GOODE M. K.	ig my					,	-
		ate	31. Date filed (Month, Day, Year) OCT 2	32. Registras Sign.	ature	hand				
	Regist	rar	301 2	O LOUS PORTING	u jo	MARCE				

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Mar	yland / Dep <i>Ce</i>	artment <i>rtificate</i>	of He	ealth a Death	nd Me		giene Reg. No.	05	35	601		
Н	Physici	an	1. Decedent's Name (First, Middle, Last)			~ ~			1	Date of Dea Month	Day	Year		ne of Death		
	/Medic		MARGARET		MA	SON				Octob):45PM		
	Examin	er	4a. Facility Name (If not institution, give s Shady Grove Nur		Rehah	4b. City, To		ille				ounty of Dea Mont		CZZ		
	Funeral		5. Social Security Number 6. Sex		(In yrs. last birthday	If Under 1		If Under 2	24 Hrs. 8	B. Date of Birth						
	Director		578-44-1331 ^{1□}	M ≱ C]√F	87 Yrs.	Min.	May 25	, 191	9. Birthplace (State Country) Maryland		nd					
	pu >		Usual Residence of Decedent 10a. State 10b. County	1	10c. City, Town or L	costion							Tand India	de City Limits		
	faryla show	ō		tgomery		herst	our	J						Yes 2 □ No		
	28a-	Director	10e. Street and Number	3 1		10f. Zip (Code				10g. Citize	n of What C	ountry?			
	h with		40 N. Summit	Ave #3		2	2087	77			Ţ	J.S.A				
	deat	Funeral		2. Was Decedent Ev Armed Forces?	rer in U.S. 13.	Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					14	Race - Am Black, Wh		ın,		
36	72 hours after death with the Maryland natural; or items 23a or 28a-f show Jical Exzourner out to motified at	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes 2				, 2,		Specify: Black				
Ö		ed b	3 Midowed 4 ☐ Divorced	Year or Dates:	16a Dece	edent's Usual	Occupa	tion			16h Kind	of Business	ss/Industry			
15	n "na	piet	(Specify only highest grade	completed)	(Give	kind of work DO NOT use	done di retired)	uring most	of working	7	TOD. KING	,				
212	d with giene ar tha	Completed	Elementary/Secondary (0-12) 5th	College (1-4or 5+)	Dor	nestic	с но	omema	aker		The	King	g Fam	ily		
nd	tal H d oth	Be	17. Father's Name (First, Middle, Last)	_						First, Middle,						
yla		은	Howard L. For				1-			a A. I						
Maryland 21215-0036	id 2 sh Ith and 27 Is n traun		19a. Informant's Name/Relationship (Type Anna Brown-Si		40 I	N. Sur	nmi i	na Numbei L AV	e #5	Route Numbe Gait	hers	own, State, burg,	MD (Sip Code)	20877		
	s 1 an f Heal item 2		20a. Method of Disposition		20b. Place of Disp	osition (Name	e of	1	Da	te	20c. Loca	tion - City o	r Town, Sta	te		
E	Page int: if		1 Burial 2 Cremation 3 Ro 4 Donation 5 Other (Specify)	emoval from State	St Paul	Churc	ch (Cem :	10/2	2/05		lesvi				
Baltimore,	Physician /Medical Examiner		21. Signature of Funeral Sancice Liceose	0						owden						
246 N. Washington St E											\111∈					
Н			shock, or heart failure/ List only on	e cause on each line.	ne death⊷ Do not en ·	ter the mode	of dying	, such as c	cardiac or	respiratory ari	rest,		Approx Interva Onset	imate l Between and Death		
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ŀ	Examiner			Due to (or as a	consequence of):											
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	ecuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last													
8760,	cate be executed physician and the burial-transit	E EX	resulting in death) cast	Due to (or as a	consequence of):											
687	death certificate be executed e attending physician and od for use as the burial-transit	edicai	d													
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	ie death the atte	icia	in the past 12 months?	1□Live birth 2 4□Pregnant at tir 9□Unknown		□Ectopic pred □ Other (spec						Month	Day	Year		
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	se de	by	Part II. Other significant conditions con Atrial Fibrill		not resulting in the i	inderlying cai	use givei	n in Part I.				contribute t		of death?		
Vital Records,	w requires been sign should be	Completed			CORCO	_				-			<u>'</u>			
Rec	The law ate has b page 2 sl	mp	Peripheral Vas	Cular Di	.sease					24a. Was a autop: perfor		prior to death?	completion	ngs available of cause of		
tal	ician: T.	e Co	Hypertension 25. Was case referred to medical					26 Place	of Death /	1 ☐ Yes Check only or		1 🗆 Ye	s 21 No			
>	S S	O B	examiner?	ospital: 1 Inpatient	2 ER/Outpatie	nt 3 DOA	Othe			e 5 Resid		Other (Spe	ecify)			
n of		n: T	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	Year) 28b. Time o	of 28	c. Injury Work		-	d. Describe h						
Sio	Attending r death. sctor: After by the fune	catic	2 Accident investigation 3 Suicide 6 Could not be			М	1 🗆 Y	es 2 □ N	-							
Division	Dirte	ertification;	4 Homicide determined	office		28	If. Location (S City or Tow		lumber or A	lural Route	Number,					
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	O	29a. Certifier	ician: To the best of	my knowledge, dea	th occurred at	t the time	e. date and	f place, an	d due to the c	ause(s) an	d manner a	s stated.			
	the Hos hin 24 h the Fur npletely	edical	(Check only 2 Medical Examinations)	ner: On the basis of e and manner state	xamination and/or is	vestigation, i	in my opi	inion, death	h occurred	at the time, o	late and pla	ace, and du	e to the cau	se(s)		
	To the To the comp	Z	29b. Signature and title of certifier			29c.	License	number		2		igned (Mon				
ŀ	1		25 Notes				עע	.0000			Oct	ober	17,	2005		
	4	1	30. Name Ta dress of person who co	mpleted cause of dea	th (Item 23a) (Type	Print)	3 Si	lver	Spi	cina.	MD 2	20910				
	Sta	to	Ravi Passi MD 8	32 Registrar	0'					- - J /						
	Registr		OCT 19 200	1000	St. An	ule										

			1 - For State Registrar	State of Ma	ıryland		irtment of tificate of			, ,	ene 1 N2 0 0 5	35602			
I	Physici		Decedent's Name (First, Middle, Last) Alfonse C. Manfr							2. Date of Death Month October	Day Year 15 2005	3. Time of Death 6:25 PM			
)	/Medio Examir		4a. Facility Name (If not institution, give s				4b. City, Town,		of Death		4c. County of Death				
	Francis		Crofton Convalesce 5. Social Security Number 6. Sex			ast birthday)	If Under 1 Yea	roftor		B. Date of Birth		Arundel			
	Funeral Director	Н		X M 2□ F	91	Yrs.	Months Day	s Hours		B. Date of Birth (Month, Day, Yeb. 20,		othplace (State or Foreign Country) ennsylvania			
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits			
	Mary e-f sh	ctor	Maryland Anne Arı	undel				Anna	apolis			1⊠Yes 2□No			
	vith the	Funeral Director	10e. Street and Number				10f. Zip Code			100	g. Citizen of What C				
	ns 23	era	1 St. Mary's Stre	12. Was Decedent E	ver in U.S	S. 13. V	Vas Decedent of	2140 Hispanic O		ify Yes or No-	U.S.A. 14. Race - American Indian.				
36	72 hours after death with the Maryland natural; or Items 23s or 28e-f show disal Evanting must be notified at	by Fur	1 Never Married XX Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 251 If Yes, Give Year or Dates:	lo	If	Yes, specify Cu	Black, White, etc. Specify: White							
5-003	72 hou		15. Decedent's Educ (Specify only highest grade			16a. Deced	ent's Usual Occ	upation	est of working	16	8b. Kind of Business/Industry				
2	and 2 should be filed within eath and Menial Hygiene. m 27 Is marked other than "her traumatic event, the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. L	NOT use retii Engin	red)	or working		Engineering				
72 pt		Be Co	17. Father's Name (First, Middle, Last)				ыды		ner's Name (First, Middle, Ma		Ineering			
Maryland		To B	Charles Manfredor			,		G	enoves	novese Buro					
Z			19a. Informant's Name/Relationship (Type Charles Manfredor				g Address <i>(Stree</i>			Route Number, C Annapoli		y or Town, State, Zip Code) S. MD 21401			
ē,			20a. Method of Disposition		20b. Pl	ace of Dispos	sition (Name of atory or other p	Ţ	Dai		oc. Location - City o				
Ē	permit. Pages 1 Department of H Important: if Ite any injury or ott		1 ☐ Burial 25 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State			: Cremat		10/18	/2005 I	Baltimore	MD			
Baltimore,	permit. Departimport any inj		21. Signature of Funeral Service Literate	len		14	Name and Add	ress of Facil	^{lity} John	M. Tayl	lor Funera apolis, M	al Home D 21401			
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ie cause on each line	Θ.	. Do not ente	r the mode of d	ing, such a	s cardiac or i	espiratory arrest	t,	Approximate Interval Between			
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	Examiner		Sequentially list conditions, b	Due to (or as a	consequ	tia						Hears.			
	ted skt	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (ог аз а солзектиелов об):											
oʻ	icate be executed physicien and s the burial-transit	Exar	that initiated events c. resulting in death) Last	Due to (or as a	consequ	ence of):									
79/8	ate be thysicie	dlcal	C d	I											
٥		(D)	IF FEMALE:	ncy					23d. Date of delivery						
C. Box	ne death certif the attending thed for use a:	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Ectopic pregnan Other (specify)	су			Month	Day Year						
7	w requires that the de been signed by the should be detached	by Ph	Part II. Other significant conditions con	tributing to death bu	t not resu	lfing in the un	derlying cause g	iven in Part	1.	23e. Did tobac	cco use contribute t	o the cause of death?			
cords,	equire en sig ould b									1 🗆 Yes	2 × № 3 □ P	robably 4 🗆 Unknown			
žeč Š	e law r has be	Completed								24a. Was an autopsy	prior to	utopsy findings available completion of cause of			
IZa I	sician: The law s certificate has b lirector, page 2 s	e Co	25. Was case referred to medical					OS Diag	a of Darsh (3 2 □ No			
<u> </u>	Physician: r this certific ral director.	To B	examiner?	ospital: 1 🗌 Inpatien	nt 2 🗆 E	R/Outpatient	3□ DOA O			Check only one 5 ☐ Residence	ce 6 □Other (Spe	ecify)			
_	D 0 0		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year)	28b. Time of Injury	28c. In	ury at ork?	28	d. Describe how					
DIVISION	Attending r death. ector: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injur	ry - At hor	me, farm, stre		Yes 2		28f. Location (Street and Number or Rural Route Number,					
ź	rs after as Inches	Cert	4 Homicide	building, etc.	(Specity)					City or Town, S	State)				
	To the Hospitel or Attendin within 24 hours after death. To the Funeral Director: Alt completely filled in by the fun	dical	29a. Certifier 1 Certifying Physical Check only 2 Medical Examin	ician: To the best of ter: On the basis of e and manner state	examinati	vledge death on and/or inv	onnumed at the astigation, in my	time data ar opinion, de	nd plane, and ath occurred	d due to the caus at the time, date	sa(s) and manifer as and place, and due	stated to the cause(s)			
	To the within To the comple	Me	29b. Signature and title of certifier	1				nse number		1	. Date signed (Moni				
•			> Ka Kush			MM		20	108		10/17	105			
			30. Name and address of person who cor Dr. Rakesh Arora					ne Ro	wie M	aryland	20715				
ń	Sta	te	31. Date filed (Month, Day, Year)	32. Paistrar	r's Signati	ure	1.0.		TLC/ P	1 Tana	20/13				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiere | 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** William Bernard Monday III 2:304 -Octobes 15,2005 /Medical 4b City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Washington Medical olen If Under 1 Year altimore burnie If Under 24 Hrs. 8. Date of Birth (Month Day, April 8 **Funeral** 5. Social Security Number 7. Age (In vrs. last birthday 1 ☑ M 2 □ F Months Days 220-56-9419 55 Yrs Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 28a-f show other treumetic event, the Medical Examinar must be notified at Director 1 XYes 2 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 310 Chesapeake Ave 'neturel', or Items 23e 21403 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 Married 1 ☐ Yes 2 No Specify: à Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 Is marked other than "appiniury or other treumetic event, II = Magney. Elementary/Secondary (0-12) College (1-4or 5+) Plant Chemist County Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William B. Monday II Florence Faudree 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles W. Fisher / Cousin 310 Chesapeake Ave. Annapolis, Maryland 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Mem. Gardens 10/20/2005 Annapolis, Maryland * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service Licensee 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ALUITE LEUKENIA disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit Cause (Disease or inju-that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Tyes 2 No 3 Probably 4 12 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? Jas page 2 ormed? 2 12 No certificate ! 2□ No 1 Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No ٥ this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Certification: 5 Pending 1 Matural death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director; 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide

Box 68760 P.O. Records, Division of Vital Hospital or Attending Physicien: 24 hours a within 2

Nilliam Monda

Baltimore, Maryland 21215-0036

29a, Certifier (Check only

29b. Signature and title of certifier

29c. License number M.D

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D0015973

29d. Date signed (Month, Day, Year) DETOBER 15, 2005

Karrehun elch 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

sesse 11500 Sutherland

and manner stated

filves sporg

20904

State Registrar

31. Date filed (Month, Day, Year) 1 8 2005



State of Maryland / Department of Health and Mental Hygie \hat{p} e0.05For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** MARY BEATRICE MINOR 10 0511:30 A /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** WILSON HEALTH CARE CENTER **GAITHERSBURG** MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🙀 F 579-26-7930 Director 81 Yrs. 5-23-1924 OKLAHOMA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "naturel", or items 23a or 28e-f show the Wedical Exercit or most be notified at 1 XYes 2 □ No Director MD MONTGOMERY **POOLESVILLE** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19000 HEMPSTONE COURT 20837 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♠ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed by 3X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any injury or other traumatic event 90cg. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **BROOKS** CLAUDINE LEWIS CLARK LOVE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19000 HEMPSTONE COURT POOLESVILLE, MD 20837 DENNIS MINOR - SON 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Tremation 3 Removal from State 10-20-2005 NATIONAL CREMATORY FALLS CHURCH, VA *4 Donation 5 Other (Specify) 22. Name and Address of Facility AFFORDABLE FUNERAL SERVICES 7400 LEE HIGHWAY FALLS CHURCH, VA 22042 23a. Part1. Enter the disease, or compiled it institute caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death **Physician** One week disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last nding physician and Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the atten d be detached for u 3 □Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Dunknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Aninica of the enal steriores! 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Histor aspiral 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physicien: 25. Was case referred to medic examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 ☑Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 14. Reliert uno erson who completed cause of BIRSCHBACH nu H.ROBSRT 31. Date filed (Month, Day, Year) Registrar's Signature. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 26 per Dr., GST UI/12/06dhb Certificate of Death Rog No. 2, Date of Death 1. Decedent's Name (First, Middle, Last) October 15, 2005 Sheilda E. Moore 8:00 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's 4401 53rd Street Bladensburg If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 11 20 4 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) D.C. 1 M 2 XF 579-58-3774 58 46 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Prince George's Landover 1y Yes 2 □ No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6600 Hawthorne Street 20785 U.S. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Specifical 1 ☐ Yes 2 No Specify: Š 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Incentive Awards Admin. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mack Curtis Warren, Sr. Elnora Norbrey ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joe Moore, Sr.-Spouse 6600 Hawthorne Street, Landover, Maryland 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 10-22-05 Lan dover, MD * 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Pk 22. Name and Address of Facility Bonnette & Assoc. Funeral 21. Signature of Funeral Service Licensee Home, 2504 28th St., N.E., WDC 20018 amald Approximate Interval Between Onset and Death 5 23a. Part 1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) years Breast Cancer Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent oregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Month Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 XNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Daughters Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 557 esidence 6 Other (Specify Residence ٩ 1 Yes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 🗌 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifies 29d. Date signed (Month, Day, Year) 29c. License number D41715 10-19-05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ste. U-3 Chitra Venkantraman, MD 6201 Greenbelt Rd., College Pk, MD 20740 2. Registrar's Signature 31. Date filed (Month, Day, Year) OCT 2 0 2005

Registrar DHMH 17 Rev 1/2001

State

Physician

/Medical

Examiner

Funeral

Director

in than "natural", or itema 23e or 28a-f show the Medical Exeminer must be notified at

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Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician:

Examine

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen of

		1	For State Registrar		State	of Mary	land / Dep <i>Ce</i>	artment of H	lealth and N Death		giene Reg. No.	105	35606
×	,3		. Decedent's Name (First	, Middle, Lasi)					2. Date of Dea Month	Day	Year 05	3. Time of Death
	Physicia /Medic	al	Ruth L.	Mart						Month 10			9:00 P M
	Examin		a. Facility Name (If not in					4b. City, Town, or Hyatts	Location of Death			ounty of Death	
			5821 Queen 5. Social Security Number				yrs. last birthday		If Under 24 Hrs.	8. Date of Birt	Date of Birth 9. Birthplace		
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	Ba-f	Director	10e. Street and Number	ince de	OIGCS		nyaces	10f. Zip Code			10g. Citize	en of What Co	untry?
	a or 2	ä	5821 Queens	Chane	1 Rd	#224		20782			0	USA	
' O	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or othar traumatic avant, It.e Medical Extratrical intelliber neilified at 2008.	교	11. Marital Status 1 □ Never Married 2		12. Was De Armed F 1 ☐ Yes	cedent Ever orces? 2 12No	in U.S.	. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No o Rican, etc.)		4. Race - Ame Black, White Specify: B1	e, etc.
21215-0036	ral', o	þ	3 ☑ Widowed 4 □ D	ivorced	If Yes, G Year or	Dates:							
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an	lid be fental rked	To B	Alfred Law	son					Ella L				
Maryland	nd 2 shoulth and N 27 is ma r trauma		19a. Informant's Name/R Geraldine (:/Niec		Ravenwood	and Number or Ru 1 Ave. Ba	lral Route Number	er, City or • MD •	70wn, State, 2 21213	Zip Code)
Baltimore,	Pages 1 all ent of Healent of Healent if item		20a. Method of Dispositio 1 ☑ Burial 2 ☐ Cre `4 ☐ Donation 5 ☐ 0	mation 3		n State	cemetery, c	position (Name of rematory or other pla ncoln Cem		Date .5-05		wood,	
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F			23a. Part 1 Enter the dis shock, or heart failu	ease, or com ire. List only	olications that one cause or	t caused the each line.	death. Do not e	inter the mode of dyi	ng, such as cardiac	or respiratory a	rrest,		Interval Between Onset and Death
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.O. Box	The law requires that the death certificate be executed tite has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent preg in the past 12 mont 1 Yes 2 No 9 Unknown			e birth 2 [egnant at tim	Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	÷y		2	3d. Date of de Month	livery Day Year
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ds	quires n sign ald be	q p	Diabetes							10	Yes 2	□No 3□P	robably 4 Unknown
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_	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical C	29a, Certifier 126 (Check only one)	Certifying P Medical Exa	miner: On the	the best of re basis of ex nanner state	camination and/c	eath occurred at the rinvestigation, in my	time, date and plac opinion, death occ	e, and due to the surred at the time	e cause(s) , date and	and manner a place, and du	s stated. e to the cause(s)
	To the within To the complex	Me	29b. Signature and title	of certifier	R.	Tu	Q	29c. Licer	150 9			e signed <i>(Mon</i>	th, Day, Year)
2	(10)		30. Name and address of Raman Tu			ause of dea	th (Item 23a) (Ty	Street Mo	unt Raini	er, MD.	2071	.2	
	S	tate	31. Date filed (Month, D		32	≥ Registrar':	s Signature						
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 7 OCTOBER **Physician** 2005 8:00a M SNYDER MARTONE MARIE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 229 Heron Point Chestertown Kent If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, De C 16. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1917 1 ☐ M 2 🖸 F Pennsylvania 87 207-03-0963 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show or other treumatic event, the Modical Exeminer must be notified at 1 ₹ Yes 2 No Director Kent Chestertown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 0 U.S.A. 21620 229 Heron Point Items 23a Completed by Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Importent: If tiem 27 is marked other than "naturel", or the any injury or other treumatic event, it a Middle Examination. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3. Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lillian Grove William Henry Snyder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19810 2146-E Culver Dr. Wilmington, DE. (daughter) Marilyn Martone 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 10/28/05 Cremation Smyrna, DE. Kent 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Galena Funeral 118 West Cross 21. Signature of Funeral Home of Stephen L Schaech St. Galena, MD. 21635 ₩00510 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Approximate fnterval Between shock, or heart Onset and Death Immediate Cause (Final disease or condition resulting in death) CASTRUCTIVE PULMWAY DISEASE **Physician** 10 Vears /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760, attending physician the as IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day ó in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part ff. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, UNG CANCETL 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy page 1 ☐ Yes 215 No 200 No or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 25 No 2 ER/Outpatient 3 DOA funeral dir 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No after death.

Director: Af
d in by the fur 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a filled 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier D0041587 10-28-2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) O1 122 Speer Rd. Chestertown, MD. 21620 Helen A. Noble, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 2 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygietaen Communication Com

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part.	Examine	_	4a Facility Name (lf not institution	give street end nur	nber)			4	b. City, Town, or	Location of Deet	h 4c. Cou	nty of Death	
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				HOWE	754		ERLIN	01/2 1	DR:	VC, ISOO	musisoro,			
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State of Maryland / Department of Health and Mental Hygien 0.05For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Richard Charles Nealan October 0 10 /Medical 2005 8:05p 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 8529 Woodville Road Mt. Airy Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 220-16-4189 1 MM 2 □ F 79 Director Yrs. July 10 1926 Kentucky Usual Residence of Decedent 10b. County ul Hygiene. other then "naturel", or items 23a or 28a-f ehow vent. Itia Medical Examir at must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Md Frederick Mt. Airy Director 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8529 Woodville Road 21771 USA filed within 72 hours after deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 WWII 1 ☐ Yes 21 No Specify: þ white 3 ☐ Widowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) excavating 8 excavator 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be filment of Health and Mental Hant: If Item 27 le marked ott Charles Nealan Martha Hester 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Nealan (spouse) 8529 Woodville Rd., Mt. Airy, Md 21771 Itimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removal from State permit Page Department o Important: If any in ury or once. Springfield Cemetery 10-13-05 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, Md 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Dage Haight Herbert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Duman **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The faw requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physicien Physician/Medicai detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year ☐Yes 2☐No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ete has been signed pege 2 should be de 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificete has autopsy performed? Yes 24 No 1 Yes 25. Was case referred to medical 26. Place of Death | Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ၉ 1 🗌 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ospitel or Attending Phyrical Sterics after death.
Inerel Director: After this y filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel o within 24 hours aft To the Funerel Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only 29b. Signarire 29c. License number ause of death (Item 33a) (Type, Print)
22 Son The Greene Street, 31. Date filed (Month, Day, Year) 32. Regi Registrar

State of Maryland / Department of Health and Mental Hygiepe00535610 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 13, 2005 **Physician** Rachel Mary Overholtzer 5:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** New Windsor 3209 Buffalo Road Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | May 04 1 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months 1 M 2004 219-10-8269 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits item 27 le marked other than "natural", or Itame 23a or 28e-f ehow other treumatic event, the Madical Exartination retitled at 1 ☐ Yes 2 ☑ No Director Maryland 10e. Street and Number Frederick New Windsor 10g. Citizen of What Country? 10f. Zip Code 3209 Buffalo Rd. 21776 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Heelih and Mental Hygiene. Importent: If item 27 is marked other than "natural; or Itan any njury or other treumatic event, the Medical Ever in excess 1 ☐ Yes 2√ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 € No Specify: þ Specify: White 35 Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Springfield Elementary/Secondary (0-12) College (1-4or 5+) State Hospital Dietary 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daisy Mae Bloom Emmanuel James Dull 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte Buffington/daughter 123 Liberty Street Westminster, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 10/17/2005 1 \ Burial 2 Cremation 3 Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Memorial Gardens Westminster, MD 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 21. Signature of Funeral Service Licessee 412 Washington Rd., Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HORTIC STENOSIA SOURIE **Physician** disease or condition resulting in death) LL EAN /Medical Examiner CORON Are Jues Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 DNo
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ATRIAL FIBRILLATION PACLOXYSMAL 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed thrombons Deep wein 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funerel Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 2 After thi funeral 27. Manner of Death 1 Anatural 2 Accident 28d. Sescribe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No i Director: / 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D31660 iamas K. Galuc in 10/13/2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 291 STONEZ AVENUE WESTAIN STER MARYLAND K. GAWIN THOMAS 31. Date filed (Month, Day, Year) 0CT 1 7 2005 Slew & Sparker State Registrar

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8	Physici /Medic		Decedent's Name (First, Middle		omas De	wight P	unt	, sr.			2. Date of Death Month	Day	Year 2005	3. Time of Deat	
1	Examir		4a. Facility Name (If not institution	n, give street and n	umber)		4b. Ci	ty, Town, or	Location of			4c. County			
		85	Washington Cou						gerst			Wa	shing		
i i	Funeral Director		5. Social Security Number 217-28-5807	6. Sex 12 M 2 ☐ F	7. Age (In yrs 73	. last birthday) Yrs.	Month Month	der 1 Year s Days	If Under 24 Hours	Min.	B. Date of Birth (Month, Day, DVember	_{Ува} 1931 19,		ace (State or For try) yland	відп
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation						11	Od. Inside City Lin	nite
	dary!	ō	Maryland Washir	arton		,,								1 DŽÝes 2 □	
	288-	Director	10e. Street and Number	19 011				n iths b Zip Code	urg		10	g. Citizen of	What Coun	trv?	
	3a of	ā	33 North Main S	Street P.	O. Box	304		217	83				S.A.		
	should be filed within 72 hours after death with the Maryland to Mental Hygiene. "Hygiene 18a or 28a or 28a-s ehow marked other the "natural", or lieme 28a or 28a-s ehow matic event, the Madical Examiner must be notified at	Funerai	11. Marital Status 1 □ Never Married 2 Marrie	Armed F	cedent Ever in l forces?	J.S. 13.	Was Der f Yes, s	cedent of His becify Cubar	spanic Origi n, Mexican,	in? (Speci Puerto Ri	ify Yes or No- can, etc.)	14. Rac	ce - Americ ck, White, e		
21215-0036	nours af ural', or LExem	ρ	3 Widowed 4 Divorced	If Yes, G Year or	evice		1 🗌 Yes	2X) No	Specify:			Specif	y: Wh.	ite	
7	in 72 h	Completed	(Specify only highe			16a. Deced	dent's Us kind of to DO NOT	sual Occupa work done di use retired)	tion u <i>ring most</i> o	of working	,	6b. Kind of B	usiness/Ind	ustry	
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פ		Bec	17. Father's Name (First, Middle,	Last)		1			18. Mother	s Name (First, Middle, M				
Maryland	should be nd Mental marked o	To E	Leo L. Punt,	Sr.					Rac.	hel l	P. Snow	berger			
an'	2 6 9 5		19a. Informant's Name/Relations			1	-				Route Number,	•		,	
	1 and 1 Health Hem 27 other tra	ı,	Marie E. Punt	(Wife)	1005					4	304 Sm.				
Baltimore,	Pages 1 nent of H int: If Ite iry or ot	-	20a. Method of Disposition 1 ABurial 2 ☐ Cremation		n State	Place of Dispo cemetery, cren	sition (N natory o	iame of r other place	No.	Dat Vembe	e^{r} 2,	Oc. Location	City or To	wn, State	
	it. Pa rtmen rtant: njury		4 Donation 5 Other (S		G	reen Hi			- 9	2005				Pennsylv	
ğ	permit. Pages Department of Important: If II any injury or o		21. Signature of Funeral Service		10-16			and Address						eral Home nd 21783	9
*	A STATE OF THE STA		23a. Parti. Enter the disease, or	complications that	caused the dea									Approximate Interval Between	
Ļ	nysician /Medical		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a	each line.									Interval Between Onset and Death	
	Examiner			Due to	o (or as a conse	quence of):	10	liac farc	+==					an older	
	ο <u>Ξ</u>	ner	Sequentially list conditions, 1 any leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	(oraș a consu		(, ,	(0						rinoics	
4	icate be executed physician and the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	o (or as a conse	guence of):	-					_			
8/60,	icate be e physiciar the buris	dical		d											
20	ng ph as th	Medi	IF FEMALE:												
X Q Q	death certif e attending id for use as	an/h	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregn birth 2 Fet	aldeath 3□	Ectopic	pregnancy					te of deliver	y Day Year	
_ o	w requires that the death certif been signed by the attending should be detached for use as	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Preg 9□Unk	gnant at time of nown	death 5	Other (specify)				1410		Jay Fear	
<u>ທ</u> ໌	requires that the een signed by th nould be detache	by P	Part II. Other significant condition	. A		sulting in the ur	nderlying	cause give	n in Part I.					cause of death?	
cords,	requi	eted	Nyper		1.4					_	1 Yes	3 2 No	3 Proba	bly 4 Unkno	₩n
He	The lar	Completed	hyper	tensia~							24a. Was an autopsy perform	ed?	Were autoportor to combeath?	sy findings availal pletion of cause of 2 No	ole of
Vitai	ysician: is certific director,	Be (25. Was case referred to medical examiner?							f Death (Check only one				
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ב	After funer	Ö	27. Manner of Death 1 Natural 5 □ Pendin	9	nth, Day Year)	28b. Time of Injury	М	28c. Injury Work	?		d. Describe hov	v injury occurr	red		
DIVISION	Attended to death octor:	ficat	2 Accident investig	not be 28e. Plac	e of Injury - At h	nome, farm, stre			es 2 □ No		f. Location (Stre	et and Numb	er or Rural	Route Number	_
5	rs efter rel Dire	Certification:	4 Hollicide	build	ding, etc. (Speci	fy)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or Town,	State)			
:	To the Hospital or Attending Physician: within 24 hours selet death. To the Funeral Director: Alfar this certifics completely filled in by the funeral director; t	edicai	29a. Certifier Certifyin 2 Medical	g Physician: To th Examiner: On the and mai	e best of my kn basis of examin nner stated.	owledge, death ation and/or inv	occurre	d at the time on, in my opi	e, date and prion, death	place, and occurred	d due to the cau at the time, dat	use(s) and ma e and place,	nner as sta and due to	ted. the cause(s)	
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					MD			D0051	4451		0	tober	30	2005	
	10		30. Name and address of person	who completed cau			-	2			100 ad45bu	-1000	180	1	53
			31. Date filed (Month, Day, Year)	un MO	229 Prodiction in Sign		Crso	~ 131	vd	Sn	11/45/50	5,1	Maryl	and	
	Sta Registr	_	31. Date filed (Month, Day, Year)	2005	Registrar's Sign	aiure A	gove.								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Heinz POSANER /Medical <u>October</u> 18. 2005 3:30 P 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1⊠M 2□F Yrs. Director 579-48-0093 71 May 6, 1934 Austria Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Itam 27 is marked other than "natural; or Items 23a or 28a-f ehow emy injury ego ther traumetic event, the Medical Examinar must be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery Rockville 1 ☐ Yes 2 🕱 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14015 Castaway Drive 20853 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ∑Yes 2 No IfYes, Give 1956–59 Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 2 1 ☐ Yes 21 No Specify: Specify: 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Floor Covering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Selman Posaner Adele Groeschler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Posaner, Wife 14015 Castaway Drive, Rockville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 10/20705 t√ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gardens Olney, MD 21. Signature of Funera Service Licenses Torchinsky Hebrew Funeral Home 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20012 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) emboli8m **Physician** umma /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the attending physicien and ched for use as the burial-transit Due to (or as a consequence of): 68760 Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year signed by the aid be detached for 5 Other (specify) o 9 Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Records, 1 Tyes 3 Probably 4 □Unknown Completed peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an paga 2 s autopsy performed (es 2 certificate Vital 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 2 npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this ð : After this funeral of 27. Manner of Death

1 Natural

2 □ Accident 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Attending Division s after dec. 5 Pending Injury М investigation 1 ☐ Yes 2 ☐ No To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by th 3 🗀 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier (Check only one) 29b. Signatur 29d. Date signed (Moeth, Day, Year) 20+1 ated cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, MD 20814 31. Date filed (Month) 32. Régistra s Signature State 0 Registrar

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			For State Registrar	State of Ma		partment of He		Mental Hygier	UUJ	35613
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	Physici /Medic		Maurice	Pressman				October 1	3 2005	= 1643 PM
)	Examin		4a. Facility Name (If not institution, give Shady grove H	re street and number)		4b. City, Town, or I	ille		Montgo	
	Funeral Director		010 03 010.	Sex 7. Age	(In yrs. last birtho	Months Davs	Hours Min.	8. Date of Birth (Month, Day, Yea	17)	rthplace (State or Foreign Country) SSACHUSETTS
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	Location				10d. Inside City Limits
	Many Ff sh	tor	MARYLAND MONTGOM	IERY	SILVE	R SPRING				ty∑Yes 2 No
	sa or 28a	I Director	10e. Street and Number 3330 N. LEISURE	WORLD BLVD	. APT.	10f. Zip Code 302 2090	6	10g. (UNIT	Citizen of What C	country? ES OF AMERICA
36	be filed within 72 hours after death with the Maryland nat Hyglene. ed other than "natural", or items 23e or 28e-f show event, the Modral Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates:		3. Was Decedent of His If Yes, specify Cuban	panic Origin? (Sp., Mexican, Puerto	pecify Yes or No- Decify Yes or No- Decify Yes or No-	14. Race - Am Black, Wh Specify:	
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ത്	l and tealth m 27 her t		EDITH Z. PRESSMA	N - WIFE		N. LEISUR			802 SPI	KING, MD 2090
Baltimore,	permit. Pages Department of H Important: If ite any injury or ot		1 \(\overline{\text{Metricol}} \) Burial 2 \(\overline{\text{Cremation}} \) 3 \(\overline{\text{V}} \) Other (Special Color)		cemetery,	MEMORIAL GA) !		NEY, MAI	
Ball	Depart Import any in		21. Signature of Funeral Service Lice	Stottle	myse	EBWARD"SAGE 1091 ROCKV	ILLE PIK	E, ROCKVII		20852
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68760	rtificate b ng physi as the b	Aedical	VE SEVALE	d						
.O. Box	that the death certifi ed by the attending detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at to 9 □ Unknown	Fetal death	3 Ectopic pregnancy 5 Other (specify)			23d. Date of de Month	olivery Day Year
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Ĭ.	Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othor		th (Check only one)	_	
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	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 Certifying P. (Check only one) 2 Medical Exe	hysicien: To the best of miner: On the basis of and manner stat	examination and/o	eath occurred at the time r investigation, in my opi	e, date and place, nion, death occur	and due to the cause rred at the time, date a	(s) and manner a and place, and du	s stated. e to the cause(s)
)	To the To the complete	Me	29b. Signature and title of certifier Alpung	Sui, me	7	29c. License	4		Date signed (Mon	
			30. Name and address of person who GGO / Medica	d Center	Brive	pe, Print) Rock	rrilly 5	Thory so	rad.	20850
	. Sta Registi		31. Date filed (Month, Day, Year)	32. legistra	's Signature	parte		J		
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State of Maryland / Department of Health and Mental Hygiene 15 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ΪŎ, **Physician** October 2005 1:40 p Poe, Sr. Russell L /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Charles Indian Head 16 Shelton Court If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days Hours 1√2 M 2 □ F Yrs 579-22-3269 79 April 23,1926 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iteme 23e or 28e-f show eny Injury or other traumatic event, the Medical Examinar response. 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2X No Indian Head Charles Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20640 16 Shelton Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Affiled Folds: 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WW II 1 Never Married 2X Married 1 ☐ Yes 2 ☑ No Specify. Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) business machine co. 10 owner 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lilly Simpson Edgar Poe 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16 Shelton Ct., Indian Head, MD 20640 Mae E. Poe, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 10/12/05 Alexandria, VA 22. Name and Address of Facility signal of Funeral Service Licen Rausch Funeral Home, P.A., Owings, MD 20736 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications to shock, or heart failule. List only one cause Immediate Cause (Final BLADDER Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): ed by the attending physician detached for use as the burial Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown cate has been signed by page 2 should be detack 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 Probably Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate has 1 ☐ Yes 2 X No Physician: the funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home Hospital: 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 1 ☐ Yes 2X No 1 🗌 Inpatient Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? After Hospital or Attending 1. Natural 2 Accident 5 Pending investigation 1 Yes 2 No after death. 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours a TCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 50 31. Date filed (Month, Day, 32. Registres Signature State OCT 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 0 05

Amend Item 26 per verb., 6849 III/02/05 thb

Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Oct. 2005 8:00 am Barbara Rachel Phillips /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner Allegany** 525 Columbia Avenue Cumberland If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F Yrs. 60 **Director** 31, 1944 Cumberland, MD 213-44-1950 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location f show rthan "netural", or Items 23e or 28e-f shovine Medical Examiner must be notified at 1X Yes 2 No Directo Cumberland MD Allegany 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 21502 USA 525 Columbia Ave. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. hours after 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2√7 Married Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Home Homemaker 8th - should be fit.
Ith and Mental Hy.
7 is mark. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Edith Mae Shingleton George Washington Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Importent: If item 27 is
eny injury or other treu Carl Eugene Phillips 525 Columbia Ave., Cumberland, MD 21502 Baltimore, 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 17 Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Oct.28,2005 Romney, WV Ebenezer Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of FacilitShaffer-Warnick Funeral Home woller mulo 35 230 E. Main St., Romney, WV 26757 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) pocardia Lavotor **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine led by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 2 Fetal death 3 ☐ Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying dause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed? 1 ☐ Yes 2 No Division of Vital 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No Nelo a sel 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this To the Funeral Director: After th completely filled in by the funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 5 within 24 hours a To the Funeral L the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1975 anjithan Vimala. H.

2

State Registrar 31. Date filed (*Month, Day, Year*)

NOV 0 3 2005

Vimala A. Ranjithan,

, 517 Oldtown Road, Cumberland, MD
32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For State Registrar	State of Ma	ryland /		artment of H rtificate of l			ierne eg. No.	005	35616
	Physicia	an	1. Decedent's Name (First, Middle, Las Peggy J	ane PORTN	ER				2. Date of Dea Month	Day	A005	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City, Town, or	Location of Death	Unare	4c. C	ounty of Death	2(13
	_Admini		Washington Count	y Hospital			Hagers	town		Wa	shingto	on
	Funeral Director		217-32-0190	9x 7. Age □M 2対F	(In yrs. last 73	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Sept.	Year) 19	32 Mary	olace (State or Foreign ntry) Land
	aryland ehow	20	Usual Residence of Decedent 10a. State 10b. County Martil and Hackingt		10c. City, To						1	0d. Inside City Limits
	he Mi	Directo	Maryland Washingt	on	Hage	rstov	Vn 10f. Zip Code			IOa Citiza	en of What Cour	
	death with the Maryland ms 23a or 28a-f ehow rimust be notified at		20313 Youngstoun				2	1742		U	.S.A.	
036	be filed within 72 hours after death with the Marylan tal Pygiene. d other then "natural", or Itema 23a or 28a-1 ehow event. Ite Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	0		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2፟፟፟ No	Specify:			Race - Americ Black, White, Specify: Whi	etc.
Maryland 21215-0036	within 72 ho ene. then "natu	Completed	15. Decedent's Ed (Specify only highest grant Elementary/Secondary (0-12)	de completed) College (1-4or 5-	+)		dent's Usual Occup kind of work done o DO NOT use retired temaker	ation during most of work ()	ing		d of Business/In	
7	filed w Hygier other th		0-8 17. Father's Name (First, Middle, Last)	0		11011	Temaker	18. Mother's Nam	o /First Middle		r own h	ome
anc	d be findal Find	Be c		Stottlemye	r Sr		and the second s					
Ž	2 should be a named of le marked o	ို	19a. Informant's Name/Relationship (7	-	-		ng Address (Street		Olivet I			
	nd 2 :		Harry Portner -	son	1	1428	National	Pike, C	lear Spr	ing,	Marvla	nd 21722
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If I tem 27 le eny Injury or other tra ance.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		20b. Place ceme	of Dispo	osition (Name of matory or other place on Cremate	е)	Date	20c. Loca	ation - City or To	
Baltir	Sermit. P Separtme mportan any Injur		21. Signature of Funeral Service Licen		mage.	22	2. Name and Addre	ss of Facility	Minnich	Fun	eral Ho	me
	4		23a Part1. Enter the disease, or come	olications that caused	the death. D						own, Ma	ryland 2174
	Di di di	W 9	23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final					g,				Interval Between Onset and Death
N.	Physician /Medical		disease or condition resulting in death)	a. RESPIR.			HURE				-	
93	Examiner			LUNG			mA					
.74		Jer	Sequentially list conditions, if any, leading to immediate cause End of London Cause (Disease or injury	Due to (or as a								
	ocuted nd transli	Examiner	that initiated events	c								
Ö O	ificate be executed g physicien and as the burial-transit	I Ex	resulting in death) Last	Due to (or as a	a consequen	ce of):						
68760,	physic the b	edical		d								
P.O. Box 6	ath certif ittending or use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of the birth alpregnant at 90 Unknown	2 Fetal de	ath 3	Ectopic pregnancy			23	3d. Date of delive Month	ery Day Year
	ires that the de signed by the a 1 be detached f	ρ	Part II. Other significant conditions of	ontributing to death bu	ut not resultin	ng in the u	inderlying cause giv	en in Part I.				he cause of death?
Secor	se faw require has been si- ge 2 should t	Completed							24a. Was autop	an		opsy findings available impletion of cause of
a			25.11						1 Yes	2 No	1 ☐ Yes	2 No
₹	sician: certific lirector,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ot 2DEB	/Outpatie	nt 3 DOA Oth	er: 4 Nursing H	th <i>(Check only o</i> o ome 5 ☐ Resid		Other (Speci	60
on of	Attending Physician: or death, ector: After this certification is the funeral director.	ion: To	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Da)		b. Time o	of 28c. Injur	4 🗆 (40)3119 (1)	28d. Describe h			(9)
Division of Vital Records,	≥ ۾ ∯ و	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ury - At home c. (Specify)	a, farm, st	reet, factory, office	703 2	28f. Location (S City or Tow		Number or Rur.	al Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best oniner: On the basis of and manner sta	examination	dge, deat and/or in	th occurred at the time	ne, date and place, pinion, death occur	and due to the orred at the time,	cause(s) a date and p	and manner as solace, and due t	stated. o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. Licens	e number		29d. Date	signed (Month,	Day, Year)
)	, , , , ,		Madhair rub					62562		10-2	2-05	
41	, ,		30. Name and address of person who								1	1 0-10 0101-0
H	1-2		31. Date filed (Month, Day, Year)		251 ar's Signature		HY TIET AM	STREET	MAGENIS	1000	M (ALC)	(AND 21740
) =×	Sta Regist		OCT 2 4 2		and dignature	. d	and the					

				rtment of Health and Men tificate of Death	ntal Hygier	.000 00017
	Physici	an	Decedent's Name (First, Middle, Last) Karen Marie Pearson		Date of Death Month	3. Time of Death 15: 30 M
	/Medic Examin	al	4a. Facility Name (If not institution, give street and number) 11712 Patrick Road	4b. City, Town, or Location of Death Hagerstown		1, 2005 15:30 M 4c. County of Death Washington
	Funeral Director		5. Social Security Number 219-68-6459 Colored Proceeding 1 → 1 → 1 → 1 → 1 → 1 → 1 → 1 → 1 → 1	If Under 1 Year If Under 24 Hrs. 8. [Months Days Hours Min. Ju	Date of Birth (Month, Day, Yea 11y 5, 1	9. Birthplace (State or Foreign Country) Washington, D.C
	Maryland e-f show	ctor	10a. State 10b. County 10c. City, Town or Loc Maryland Washington Hagerston			10d. Inside City Limits 1 ☐ Yes 2 ½ No
	h with the 23a or 28	Funeral Director	10e. Street and Number 11712 Patrick Road	10f. Zip Code 21742-4349	10g. (Citizen of What Country?
036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortent: if item 27 is marked other then "neturel", or Items 23e or 28e-1 show injury or other treumatic event, the Medical Exaction must be notified at each 18e.	þ	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	Vas Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Rica ☐ Yes 2☒ No Specify:	Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc. Specify: white
21215-0036	d within 72 ho piene. r then "netur the Medical	Completed	15. Decedent's Education 16a. Deced (Specify only highest grade completed) 16a. Deced (Give life. L.	ent's Usual Occupation kind of work done during most of working NO NOT use retired)		Kind of Business/Industry
land	uld be filed fental Hyg rked othe lic event,	To Be C	17. Father's Name (First, Middle, Last) Delbert Brooks	18. Mother's Name (Fir	rst, Middle, Maid Martha	en Sumame)
Maryland	ind 2 shou aith and M 27 is mai		1 1 1 1 1	g Address (Street and Number or Rural Ro 2 Patrick Road, Hage		
altimore,	Pages 1 and the out: If item		20a. Method of Disposition 1 □ Burial 2 ▼Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify) 20b. Place of Disposicementary, crem Hagerstow	on Crematory Cotobe		Location - City or Town, State Serstown, Maryland
Balti	permit. Pages Department of Importent: ff i any injury or once.		7 0 1	Name and Address of Facility Min	nich Fu	neral Home stown, Maryland 21740
The second	Pnysician /Medical Examiner	Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each lin. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury)	r the mode of dying, such as cardiac or res phoblash'c	spiratory arrest,	Approximate Interval Between Onset and Death Onset Approximate
,820,	death certificate be executed e attending physician and d for use as the burial-transit		that initiated events resulting in death) Last C. Due to (or as a consequence of): d.			
.O. Box 6	the death certific y the attending p iched for use as t	Physician/Medical		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
ords, P.	The law requires that the de ite has been signed by the a bage 2 should be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
Vital Records,		Completed	, congestive hear	1 former	24a. Was an autopsy performed? 1 ☐ Yes 2	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
of	S S	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2		× 1	6 □Other (Specify) jury occurred
Division	iet or Attendi s after death. el Director: A ed in by the fu	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, streed building, etc. (Specify)	et, factory, office 28f. L	Location (Street City or Town, Sta	and Number or Rural Route Number, te)
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or invand manner stated.	estigation, in my opinion, death occurred at	due to the cause it the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
	To the within To the comple	Δ	29b. Signature and title of certifier When the signature and title of certifier Methods and	29c. License number D46473	29d. 0	Date signed (Month, Day, Year) $10/24/05$
óН	-5		30. Name and address of person who completed cause of death (Item 23a) (Type, F	OPAL CT.	Hager	stown, MD 21740
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 4 2005 32. Registrar's Signature Section 5.	ale	V	

DHMH 17 Rev 1/2001

Registrar

OCT 2 0 2005

State of Maryland / Department of Health and Mental Hygiene 05 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 18, 2005 **Physician** 1:58 Lillian Augusta /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Prince George Fort Washington Fort Washington Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🙀 F Mar.14,1908 Pennsylvania Director 707-10-0431 Usual Residence of Decedent 10a State 10b. County 10c, City, Town or Location 10d. Inside City Limits ul Hygiene. othar than "natural", or Items 23a or 28a-f show vant, the Madical Experiment oust be notified at 1 ☐ Yes 2 ☐ No Director MD Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20601 10756 Cedarwood Dr. USA by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married Specify: White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify. 3 NWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) <u>Administrative Clerk</u> Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fit inent of Health and Mental H tant: If item 27 is marked off jury or other traumetic avan Be William F. Macneal Charlotte E. Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10756 Cedarwood Dr. Waldorf ce of Disposition (Name of Date 20c. Le Mary P. Dent/Daughter orf, MD 20601 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) October Depertment of Important: If any Injury or once. 21,2005 Holy Cross Cem. Lansdowne, PA 21. Signature of Funeral Service Licensee Brinsfreld-Echols Funeral Home, PA P.O. Box 128 Charlotte Hall, Md. 20622 M00641 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Examiner physicien and the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? ģ Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 icete hes been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 Probably 4 🗹 Unknown Be Completed 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 1 No 1 ☐ Yes funeral director 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 € No 1 🗆 Inpatient Certification: To 2 ✓ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after deati To the Funerel Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 ☐ Certifying Physician: To the hest of my knowledge, death constraint the time, date and plane, and due to the nawse(s) and a anner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the st 29b. Signature and title of certific 29c. Licensa number 29d. Date signed (Month, Day, Year) A42509 30. Name and address of parmn who completed cause of death (Item 23a) (Type, Print) 12070 OH line Conto NDZON SMITH Mis 32. Reg Strar's Signature 31. Date liled (Month State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death OCTOBER **Physician** Day 4,2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HEBREW HOME OF GREATER WASHINGTON ROCKVILLE
If Under 1 Year | If Under 24 Hrs. MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 578-52-7678 1 ☐ M 2 🖫 F 102 Director Vrs MARCH 27, 1903 WASHINGTON, DC Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumatic avant, the Medical Examiner must be notified at Yes 2□No Director MARYLAND MONTGOMERY ROCKVILLE 10e. Street and Numbe 10f. Zin Code 10g. Citizen of What Country? ö 6121 MONTROSE ROAD 20852 "natural", or Itams 23a UNITED STATES OF AMERICA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or Iter Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 WHITE 1 Yes 2 No δ Specify 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ATTORNEY GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be AZREAL FURR REBECCA TORKENITCH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is any injury or other transports ALFRED OPACK - NEPHEW 6 OLD CREEK COURT, ROCKVILLE, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 5 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State OHEV SHALOM CEMETERY 10/17/05 * 4 ☐ Donation 5 ☐ Other (Specify) WASHINGTON, DC 21. Signature of Funeral Service Licensee any in BANZANSKY GOLDBERG MEMORIAL CHAPEL, INC. ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner inding physician and use as the burial-transit To the Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by 4 Dunknown 1 ☐ Yes 2 ☐ No 3 Probably page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform No No 2 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other. 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Man or of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred After 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation М 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \(\text{Homicide} \) 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) thin 2 the f 29b. Signature and title of gertifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and addre 31. Date filed (Month, Day, Year) Registrar

			State of Maryland / Dep. I - State Registrar Ce	artment of Health and Me rtificate of Death		2005 35621
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
	Physicia /Medic		Betty Jo Rawlings		October	17, 2005 8:00 P.M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	,	4c. County of Death
			1120 Boyds Road	Prince Frederi		Calvert
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday,	Months Days Hours Min.	B. Date of Birth (Month, Day, Y Jan. 8,	(ear) 9. Birthplace (State or Foreign Country) Virginia
200	* =		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
Z 4	f show lied at	ţō	MD Calvert Prince	Frederick		1 ☐ Yes 2 反 No
đ	r 28e	Funeral Director	10e. Street and Number	10f. Zip Code	10g	g. Citizen of What Country?
.3	23a o	ai D	1120 Boyds Road	20678		U.S.A.
<u></u>	su e	iner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	ify Yes or No- lican, etc.)	14. Race - American Indian, Black, White, etc.
2 4	ral', or items 23a or 28e-f shov Examinational be notified at	by Fu	1 ☐ Never Married	1 ☐ Yes 2X No Specify:		Specify: white
	"natural",			dent's Usual Occupation	16	b. Kind of Business/Industry
2 2	n "na	Completed	(Specify only highest grade completed) (Give	kind of work done during most of working DO NOT use retired)	9	
4 E	than	E O	Elementary/Secondary (0-12) College (1-4or 5+) 12 del:	icatessen worker	d	delicatessen
THE KIKING TO POINTS after death with the Maryland	othe othe vent,	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma	iden Sumame)
ָבָּר בַּ	Venta rrked tic e	ToE	unobtainable	Hazel S	outherly	7
should	and I	Ċ		ing Address (Street and Number or Rural		
# 6200	m 27 m 27 ner tr			Boyds Rd., Prince		
Page 1	t of Health and Mental Hygiene. If item 27 is marked other than "nature or other traumetic event, the Medical		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remyoval from State ASDURY Cre ASDURY	matory or other place)		Oc. Location - City or Town, State Barstow, MD
6	tmen rtant: vjury		'4 Donation 5 Other (Specify)		172003	
מון	Department of Health and Mental Hygienen Important: If item 27 is marked other than any injury or other traumetic event, I'm M. Once.			2. Name and Address of Facility ausch Funeral Home,	P.A., (Owings, MD 20736
	hysician		23a. Part1. Enter the disease, or complication, that caused the death. Do not en shock, or hear the lure. List only one cause on each line. Immediate Cause (Final disease or condition a.	ter the mode of dying, such as cardiac or		
	/Medical xaminer		resulting in death) Due to (or as a consequence of):			
		e	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):			1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
pot	ansit	ш	cause. Enter Underlying Cause (Disease or injury			
oo,	an and rial-tra	Examin	that initiated events c. The strict initiated events consequence of			
5 8	ohysician and the burial-transit	cai	d			
	ng ph	Medi	IF FEMALE:		- Wol	
The law requires that the death confliction	he attending ph	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 0 23c. If yes, outcome or pregnancy 1 Live birth 2 Fetal death 3 (4 Pregnant at time of death 5 (Ectopic pregnancy Other (specify)	· · · · · ·	23d. Date of delivery Month Day Year
7. 19.	ed by the a	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the	inderlying cause given in Part I	23e. Did toba	cco use contribute to the cause of death?
, and a	been signed t	ted by	Taken. Othor Significant Conditions Contributing to Goden But not recoming in the	and the second s	1 🗆 Yes	\
ב נ	as be	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
	page	S			performe	death?
V110	certificate has rector, page 2	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death		
5	After this certificate ha	2	1 ☐ Yes 2 ☐ Toophian 1 ☐ Inpatient 2 ☐ ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time of		e 5 🔀 Resident 3d. Describe how	ce 6 Other (Specify)
5	After funer	tion	1 Pending (Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No	30. D03011B0 110W	mjury occurred
7	de att	flea	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, st			et and Number or Rural Route Number,
	a after	Certification:	4 Homicide determined building, etc. (Specify)		City or Town,	Srare)
9	within 24 hours after death To the Funerel Direct, r. After this certification is a second of the funeral director, it	edicai C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dea miner: On the basis of examination and/or is and manner stated.			
4	withir To th	Me	29b. Signature and title of certifier	29c. License number	1	I. Date signed (Month, Day, Year)
			100	1)00522	42	10/18/05
	5		30. Name and addr as of person who completed cause of death (Item 23a) (Type J. John Barth, III, MD 110 Hospital		rince Fre	ederick, MD 20678
	Sta Registi		31. Date filed (Month, Day, Year) OCT 2 0 2005 Signature	4		

7. Age (In yrs. last birthday)

Certificate of Death

4b. City. Town, or Location of Death

Prince Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

Days

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

1 ☐ M 2**X**) F

Calvert Memorial Hospital

Joan Robertson

5. Social Security Number

577-42-7557 Usual Residence of Decedent

Physician

/Medical

Examiner

Funeral

Director

State

DHMH 17 Rev 1/2001

Registrar

5851

31. Date filed (Month, Day, Year)

Deale

OCT 1 4 2005

churchton

32. Registra/s Signature

35622

Reg. No.

2. Date of Death 3. Time of Death October 12, 2005 5:25 A

4c. County of Death Calvert County

8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)

21, 1932 Virginia

10d. Inside City Limits 1 Yes 2 No

10g. Citizen of What Country?

U.S.A.

14. Race - American Indian, Black, White, etc. Specify: White

16b. Kind of Business/Industry St. Mary's Board of

Education 18. Mother's Name (First, Middle, Maiden Sumame)

Frances Leona Curry

2250 Deer Run Court, Huntingtown, Maryland 20639 are of Disposition (Name of Cotton Date 17 20c. Location - City or Town, State Dunkirk, Maryland

22. Name and Address of Facility Loe Funeral Home Calvert, P.A.

8125 Southern Maryland Blvd., Owings, MD 20736 Approximate Interval Between Onset and Death

Cholangio carcinoma

23d. Date of delivery Day

> performed 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

10-12-2005

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Dey, Year)

SURANA

GYAN - C. S Road Deale

MD

For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Rohan October | 2005 10:15 p Bradley Charles /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1∏M 2□F Director 11 Sep 23, 2005 Maryland none Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County iral", or items 23a or 28a-f show Examiner must be rutified at 1 ☐ Yes 2 → No Director Churchton Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20733 USA 1117 Cape Anne Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No tf Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after cannot of Health and Mertal Hybjene.
ant; if Item 27 is marked other than "natural", or Item ury or other thaumatic event, Ite Machical Examinatiny or other thaumatic event, Ite Machical Examination 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Specify: Specify þ 3 Widowed 4 Divorced white Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coltage (1-4or 5+) none none 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Rohan Stephanie Bradley 2 Anne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1117 Cape Anne Way, Churchton, MD 20733 Stephanie A. Rohan, mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, Stete permit. Pages 1
Department of H
Important; If Ite
eny injury or otl
once. 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Southern Mem. Gardens 10-07-05 Dunkirk, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility William Rausch Funeral Home, P.A., Owings, MD 20736 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Finat disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the deriving Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 Tyes 2 TNo 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed 2 **X**No 1 ☐ Yes 2 ☐ No certificate 1 Yes To the Hospital or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; Aiter Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director; the 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Dev. Year) 047158 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 Medical Pkny

DHMH 17 Rev 1/2001

State

Registrar

ORIGINAL

MD

Lin

7 2005

32. Registre s Signature

Jann-Jann

OCT -

31. Date filed (Month, Day, Year)

05-7007 B.K.S MAGDA N. CARRILLO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 15 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2005 Month Revolorio De Carrillo **Physician** Nidia Magda 15, OCT. 0648 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES HOSPITAL CENTER CHEVERLY PRINCE GEORGES 8. Date of Birth (Month, Day, Year) 2/14/1968 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6 Sax 7. Age (In yrs. last birthday) Funeral^{*} Months Days Hours 1 ☐ M 2 🛣 F Guatemala 37 Yrs. 478-25-3775 Director Usual Residence of Decedent nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland ariment of Health and Mental Hygiene.
ortent: if Item 27 is marked other than "neturel", or Iteme 23a or 28a-f show Injury or other traumatic event, in Madical Examination in a confidence. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Montgomery 1 ☐ Yes 2 No Silver Spring Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13240 Old Columbia Pike 20904 Guatemala Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Yes 2 No 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) House Cleaning House Cleaning 6 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Teresa De Jesus Cristal Jesus Revolorio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod20904Gilberto Revolorio/Brother 13240 Old Columbia Pike Silver Spring, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State 10/22/05 Gate of Heaven Silver Spring, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee PHILIP D.RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each fine. fmmediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, Examiner If any Isaams 12 immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): by Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ∠Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 📉 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To XXYes 2 □ No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred fnjury 1 Natural 5 Pending

The law requires that the death certificate be executed as the burial-transit use ō detached bete hes been signed page 2 should be detent After this certificete hes funeral director, page 2: Attending Physician: death. within 24 hours after death To the Funeral Director: completely filled in by the

0

physician

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Department o Important: If any Injury or

permit.

2 Accident

investigation 6 Could not be determined 4 Homicide

Oct 14,2005 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6:45 P

1 ☐ Yes 2 ☐No

pedes hion stret by we hicke.

28f. Location (Street and Number or Rural Route Number, City or Town, State) Rt 202 Sort of Bay lowe Careloven Mil

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29c. License number

111 PENN STREET, BALTIMORE, MARYLAND 21201

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier ast

O.C.M.E

t Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

OCT. 16, 2005

Tasha Zlineenberg M.D 31. Date filed (Month, Day, Year) State

3 Suicide

29a. Certifier

19 2005 32 Registrar's Signature

MID

Registrar

		For State Registrar		State of	Marylan		partment of F Certificate of			ntal Hy	gien Reg. N	uua	35625
		Decedent's Name (First, Middle	Last)					2.	Date of De			3. Time of Death
Physicia /Medica		MARIA REY							00	tobe	r 06	2005	10:50 ^M
Examine		4a. Facility Name (If n			ber)		4b. City, Town, o				1	c. County of De	
Farment		FAIRLAND 5. Social Security Nun			. Age (In yrs.	last birthd	SILVER ay) If Under 1 Year	If Unde		Date of Bi (Month, Di		ONTGOME 9. B	IKY inthplace (State or Foreign Country)
Funeral Director		595-82-01		1□M 2★□F	61	Yrs	Months Days	Hours				.1943	NICARAGUA
p z		Usual Residence of D			10c Cit	y, Town o	r Location						10d. Inside City Limits
Aaryla f sho	ō		MONTGO	MERY	i		PRING						1 X Yes 2□No
r 28e-	Director	10e. Street and Numb	өг				10f. Zip Code				10g. C	itizen of What 0	Country?
th with	a D	2101 FAIR	LAND R	OAD			209	04			NIC	ARAGUA	
IIS 8	ed by Funeral	11. Marital Status 1 Never Married 3 Widowed 4		If Yes, Give Year or Da	ces? 2 X No		13. Was Decedent of In If Yes, specify Cub 1 Yes 2 No eccedent's Usual Occup	Specify	NITCAL			14. Race - An Black, Wh Specify: HI	ite, etc. SPANIC
nin 72 in "na Medic	plet	(Specify	only highes	t grade completed) College (1-	40(5+)	(G	ive kind of work done e. DO NOT use retire	during mo d)	st of working				
77 75 6 60	Completed	6th	*	College (1-	401 34)	JAN	ITORIAL	,			JAN	ITORIAL	SERVICES
be file ital Hy id oth event	Be	17. Father's Name (Fi							her's Name (F			•	
12 should be filed within in and Mental Hyglene. 7 Is marked other then "reumatic event, the Nex	^c	TOMAS REY				19h M	ailing Address (Street		ADALUPE				Zin Code)
2 = 2 -		JORGE SAN					0 16TH Str						
es 1 and 2 of Health fitem 27 r other tr		20a. Method of Dispo		3 □Removal from S		Place of Di cemetery,	sposition (Name of crematory or other pla	сө)	Date	•	20c. l	ocation - City o	r Town, State
Pages ment of ant: If it		° 4 □ Donation 5	Other (Sp	ecify)		ORGE	WASHINGTON		10/11/2				ARYLAND
permit. Pages Department of Important: If i eny injury or o		21 Signature of Fune	aral Sarvice (icensee		-	22. Name and Addre						FUNERAL, II
	-	23a. Part 1. Enter the	disease, or	complications that ca	used the deat	-	enter the mode of dyin					п. Б. С	Approximate
Physician		Immediate Cause (Fi		only one cause on ea		oostd	ial Infar						Interval Between Onset and Death
/Medical		disease or condition resulting in death)		- u.	ras a conseq			-L					
Examiner	_	Sequentially list cond if any, leading to imm	litions,	b. — Due to /e	or as a conseq								
pet nsit	Examiner	Cause (Disease or in	nediate /ing jury	Due to (c	or as a conseq	juence or):							
be executed sician and buriat-transit	Exar	that initiated events resulting in death) La	st	C. Due to (c	r as a consec	juence of):							
ficate be executed physician and is the burial-transi	edical			d									
	/Med	IF FEMALE:	_	23c. If yes, outc	ome of progn	2004						0015. (1	
The law requires that the death certificate has been signed by the attending bage 2 should be detached for use as	Physician/M	23b. Was decedent p in the past 12 m 1 Yes 2 Unknown	onths?	1 ☐ Live bir	nth 2 ☐ Feta ant at time of c	l death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у				23d. Date of d Month	Day Year
es tha igned be de	ру Р				ath but not res	ulting in th	e underlying cause gr	ven in Par	t I.				to the cause of death? Probably 4 Unknown
w requir been s	eted	Hypert	ensio	<u>1</u>							Yes 2	A	
	Completed	Diabet								1 Yes	opsy ormed? 2 \(\D\) N	death?	autopsy findings available completion of cause of
	To Be	25. Was case referre examiner? 1 ☐ Yes 2 ☐ N		Hospital: 1 🗆 In	patient 2	ER/Outpa	atient 3 DOA Ott	hor	ce of Death (C Nursing Home			6 □Other (Sp	ecify)
al or Attending Physical distributions at the death. I Director: After this dinby the funeral di		27. Manner of Death	5 Pendine	28a. Date o	f Injury n, Day Year)	28b. Tim Inju						ury occurred	
tendir leath. tor: A the fu	Certification:	2 Accident	investig	ation	-			Yes 2[Logation	/Ctmat a	and bloomban and	Dural Pauta Number
or At after o Direc in by	ertifi	4 Homicide	determi	ned 289. Place	g, etc. (Speci	ome, tarm fy)	, street, factory, office		201.	City or To	wn, Sta	te)	Rural Route Number,
spital							leath occurred at the ti						
To the Hospital or within 24 hours after To the Funerel Direction completely filled in b	edical	(Check only 2 one)	Medical I	Examiner: On the ba and mann		ation and/o	or investigation, in my	opinion, de	eath occurred	at the time			
To t To t	Σ	29b. Signature and ti	1	:M 5)		29c. Licen:	se number	r		29d. D	ate signed (Moi	nth, Day, Year)
(2)			usha			- 02-1 CF		D0061	096		0ct	ber 11,	2005
		30. Name and address	s or person on the same of the	M.D. Sh	225 adv Gr	ove I	Road; Suite	e 208	: Rock	vi]le	.Mar	vland.	20850
Sta		31. Date filed (Month	, Day, Year)	2005	gistrar's Signa	ature	head!		, moon		,1	<i></i>	
Registr	ar	00	T 2 0	2005	we s	5 /9	7 Maria						

State of Maryland / Department of Health and Mental Hygierie () 0.5For Stata Registrar 1-Certificate of Death Reg. No. 2. Date of Death cedent's Name (First, Middle, Last) 3. Time of Death **Physician** Year IVIAN 0 2008 2006 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7A NNAPOLIS rundel (Den. 105P If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Months Hours 10 M 20 F 166-32-2162 Yrs. Director 63 Pa. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2/☐ No Director De. Sussex Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 32120 Old Stage Rd. 19956 USA Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Yes 2 Pho Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify Specify: White þ 3 ☐ Widowed 4 ₺ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cosmetics Sales Representative 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) nt of Health and Mental H
t: If item 27 Is marked ott
v or other traumatic sven Bobette Sutter Arthur Lechner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32120 Old Stage Rd. Laurel, De. 19956 Theresa K. Barnes, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Crematory of Delmarva 10/20/2005 * 4 ☐ Donation 5 ☐ Other (Specify) Delmar, De. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home, Inc. Grun E. Grove St. Delmar, De. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Typevteusive
Due (or as a consequence of): rdie v. **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine physician and s the burial-transit to the Hospital or Attending Physiclan: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the at the detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Z inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No certificate 2 No 1 🗌 Yes 25. Was case referred to medical examiner?

1 ★Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification; 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death To the Funeral Director: occupletely filled in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funeral Dire 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical eputy 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D000605 person who completed ause of death (Item 23a) (Type, Print) ONES 31. Date filed (Month, Day, Year)
OCT 2 0 2005 32. Registrar's Signature State Sparke Registrar

			1 - State Registrar 1. Decedent's Name (First, Middle, Last)	tate of Maryland /	Certifica	te of Deat	<u>2. D</u>	Reg. ate of Death	THE ALL AND ADD	3. Time of Death
	Physici /Medi		Charles Calvin Stu		0			TOBER	24 2005 4c. County of Deat	9:04 p M
	Examir	ner	4a. Facility Name (If not institution, give stree St. Mary's Hospital	et and number)		, Town, or Location		i	St. Mar	
	Funeral Director		5. Social Security Number 6. Sex 1四 M	2□ F 7. Age (In yrs. last b	Yrs. If Under Months		er 24 Hrs. 8. D Min. 7-	ate of Birth Month, Day, Ye -31-191	9. Birt Co Mar	hplace (State or Foreign unity) yland
	aryland show	2	Usual Residence of Decedent 10a. State 10b. County		wn or Location					10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	the M	Director	MD St. Mary 10e. Street and Number	's Clem		ip Code		10g.	Citizen of What Co	untry?
	3s or	I Dir	39020 Sonnie Way			20624			United St	ates
980	perrit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland perrit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show ary injury or other traumatic event; the Medical Event is enmitted at any injury or other traumatic event; the Medical Event is enmitted at	by Funeral	T. Maria Ciara	Was Decedent Ever in U.S. Armed Forces? 1 🛪 Yes 2 🗆 No 1944 If Yes, Give Year or Dates: 1946	1 ☐ Yes	edent of Hispanic (ecify Cuban, Mexic 2X No Speci			14. Race - Ame Black, White Specify: Wh	e, etc. ite
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2	ic eva	To Be	Millard C. Stull				Beulah A	Amoss		
Mony	nd 2 shou lith and M 27 is mar	-	19a. Informant's Name/Relationship (Type, Kelley Quade / Da						ity or Town, State, icsville,	Zip Code) MD 20659
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	perrit. Departminents Imports aryinju		21. Signature of Funeral Serill Licensee Edward N. Brinsfiel	Jr., M00052					Tuneral Ho dtown, M	
	Physician		23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of Immediate Cause (Final disease or condition	ions that caused the death. Do	o not enter the m	ode of dying, such	as cardiac or res	piratory arrest	,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence						
	ecuted and transit	amine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	el aro	hoca				
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C	Ords, P.O. BOX 66/00, requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown					23d. Date of de Month	livery Day Year
3 9	COLGS, P. C w requires that the s been signed by should be detact	d by Ph	Part II. Other significant conditions contri	buting to death but not resulting	g in the underlyin	g cause given in Pa	art I.		cco use contribute to 2 □ No 3 □ P	o the cause of death?
CALVIN S	fec e taw has b	Completed by						24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
CA	ysician: Thysicate is certificate director, pag	Be (25. Was case referred to medical examiner?	spital:		Other	ace of Death (CI			
		ion: To	27. Manner of Death 1 Natural 5 Pending	I mpatient 2 LEN	Outpatient 3 December 1 December 1 December 2 December	DOA 4 ☐ 28c. Injury at Work? 1 ☐ Yes 2	28d.		ce 6 Other (Spe injury occurred	ecify)
CHA	or Attendition of Attendition of Attended Internsional Contractor: in by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, street, fac	tory, office	28f.	Location (Stre City or Town,	et and Number or R State)	lural Route Number,
•	Hospital 4 hours Funaral	ledical C	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examine	tian: To the best of my knowled r: On the basis of examination and manner stated.	dge, death occurr and/or investigat	ed at the time, date ion, in my opinion,	e and place, and death occurred a	due to the cau t the time, date	se(s) and manner a e and place, and du	s stated. e to the cause(s)
	To tha Hos within 24 hr To tha Fun completely	Me	29b. Signature and title of certifier	ah		29c. License numb	7066	290	Date signed (Mon	
	*6		30. Name and address of person who com					MD 2065		
	S	tate	Avani D. Shah, 31. Date filed (Month, Day 2017) 2 6 2				Lucown,	בט 2005) U	

State of Maryland / Department of Health and Mental Hygiene 15 35628 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 18, 2005 11:00 AM Μ. Salotti /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Wheaton Randolph Hills Nursing Home If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) 1921 **Funeral** Birthplace (State or Foreign Country) 1□ M 2 1 F Months Days Hours Min. 177-16-7721 83 Pennsylvania Director October 20, Usual Residence of Decedent Maryland 10a, State 10b. County 10c, City, Town or Location 10d. Inside City Limits 28a-f shov 7 is marked of the than "natural", or Itams 23a or 28a-f show traumatic event, the Medical Eventuer invalies to retilied at Maryland Montgomery Rockville 1 ☐ Yes 2 TNo Directo the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13716 Flint Rock Road 20853 United States Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death ment of Heath and Mental Hygiene.
ant: if item 27 is marked other than "natural", or flams 23 ant: ury or other traumatic event, it is Medical Exertine must ny or other traumatic event, its Medical Exertine must. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 XWidowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Consultant Telecommunications 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mike Posick Rosie Stipkovic 2 19a. Informant's Name/Relationship (Type, Print)
Joan Kennedy/ Niece 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13716 Flint Rock Road, Rockville, MD 20853 Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other pla Gate of Heaven Cemetery Date 20c. Location - City or Town, State Silver Spring, 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit, Page Department of Important: If any injury or once. October 24, 2005 4 □ Donation 5 □ Other (Specify) Maryland 21. Signature of Funeral Vice Libens 22. Name and Address of Facility DeVol Funeral Home, M00689 10 East Deer Park Drive, Gaithersburg, MD 20877 23a Party Enter the disease, or complications that cause whe death. Do not enter the mode of dying, such as cardiac or respiratory arrest, short, or hear/failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ACUTE MYOCARDIAL INFARCTION HOURS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Licease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner burial-transit or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. physician the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Ø No Month Year Day 4□Pregnant at time of death 5 Other (specify) P.O. be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown DEHYDRATION page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2/No 1 Yes of Vital director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Dther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 T Homicide pelli Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated within 2 To tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ပ D14876 10-20-05 Juny alla 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Suresh C. Gupta, M.D., 4701 Randolph Road, #203, Rockville, MD 20852 Suresh C. Gupta, M.D., 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2005 Registrar

35629 State of Maryland / Department of Health and Mental Hygie () 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** OCTOBER 14, 2005 CARL STULMAN 9:46A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BETHESDA
If Under 1 Year If Under 24 Hrs. SUBURBAN HOSPITAL MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 10 M 2 □ F 577-62-0276 86 Yrs Director ROMANTA DEC. 24, 1918 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b County 10d. Inside City Limits rai', or iteme 23a or 28e-f show Examinar must be notified at 1 ☑ Yes 2 ☐ No Director MARYLAND MONTGOMERY BETHESDA 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20814 UNITED STATES OF AMERICA 5208 ACACIA AVE Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced other then "natu 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ACCOUNTANT PRIVATE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental is marked ည MARCU STULMAN REBECCA POLKIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Important: If Item 27 is any injury or other treu DR. JULIAN SAFIR - NEPHEW 37 CLOCKTOWER LANE, OLD WESTBURY, NEW YORK, 11568 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 Pemoval from State 4 ☐ Donation 5 ☐ Other (Specify) KING DAVID MEM. GARDS. 10/16/05 FALLS CHURCH, VIRGINIA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DANZANSKY GOLDBERG MEMORIAL CHAPEL, INC 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL **Physician** INFARCTION 3 HRS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical 1 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ped 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 3 ☐ Probably 4 ☐ Onknown CARCINOMA 1 ☐ Yes 2 ☐ No Completed 7 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 1 Inpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred funer Certification: After 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident Director: 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 3 within 24 hours a
To the Funeral Completely filled etely filled MAG 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number OCT. 15,2005 D-23308 30. Name and address of person completed cause of death (Item 23a) (Type, Print) 10 6420 POCKLEDGE DR. #4100 BETHES DAMD. 20817 VICTORM. PRIEGO MO 31. Date filed (Month, Day, Year) 32 Registrar's Signature State OCT 2 0 2005 Registrar

David Starkey 05-07228 NJM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene O C

			For State Registrar	State of M			ent of Healtr ate of Deat			giene [] [15	3563	3 U
3	Physicia	an	Decedent's Name (First, Middle,						2. Date of Dea Month October	ıth	2005	3. Time of 8	Death M
	/Medic	_	David Ross Sta 4a. Facility Name (If not institution,			4b. C	ity, Town, or Location	on of Death	october		ty of Death	1025	
edi. Sign	Examin	ier	Dorchester Gene				mbridge				hester		
24	Funeral			6. Sex 7. Ag	e (In yrs. last birti		der 1 Year If Und		8. Date of Birth (Month, Day	1		lace (State or	Foreign
	Director	2	213-68-8201	1 X]M 2□F	49	rs.	15 Days Hour	3 141111	Sept 5	1956	Mary		
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					1	0d. Inside City	Limits
	Maryi feh	ō	Maryland Dorch	ostor	Cor	nbridge	•					1 X Yes	2 🗌 No
	the 28e-	Director	10e. Street and Number	ester	Cal		Zip Code	****		10g. Citizen o	f What Cour	ntry?	
	death with the Maryland me 23a or 28e-f ehow Emust be notified at		5255 Gipsey Dr	ive			21613			U.S.A	١.		
	deat	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S.	13. Was De	cedent of Hispanic specify Cuban, Mexic	Origin? (Spe	ecify Yes or No- Rican, etc.)	14. Ra	ace - Americ		
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Baitimor	permit. Pag Department Important: eny injury o		21. Signature of Funeral Service L	icensee 6			and Address of Face gle and Hoox 160 Gr		oein Fun	eral.	Home,	PA	
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12	/Medical		disease or condition resulting in death)	a. 1 0	a consequence of	A	The word	100	owe be	213			
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5	s afte	Certification:	4 Homicide	building, e	tc. (Specify)				City or Tow	n, State)			
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				770			111 Dans	Ctros	+ Pol-	October imore,	r, 26,	2005	201
			30. Name and address of person	wno completed cause of	death (Item 23a) (type, Print)	III renn	priee	t Dalt	more,	пагу1	and 41	201
30	Sta	ate	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature						-		
	Registr		OCT 28	43	-	Source							

		For State Registrar 1. Decedent's Name (First, Middle, Last)		rtificate of Dea	2. Date of Dea	eg. 776. UU5	35631 3. Time of Death
Physici		Clara Marie Schmidt			Month 10	19 2005	7:59am
/Medic Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loca		4c. County of Deat	
		Ravenwood Lutheran Village		Hagersto		Washing	
Funeral Director		5. Social Security Number 215-01-2205 Usual Residence of Decedent 6. Sex 1 □ M 2 ☒ F 7. Age (In y 88	vrs. last birthday) Yrs.		nder 24 Hrs. urs Min. 8. Date of Birth (Month, Day)	,1916 M	hplace (State or Foreig untry) aryland
how			. City, Town or Lo	ocation			10d. Inside City Limit
Ba-f s	Director	Maryland Washington	Hag	erstown			1 🖾 Yes 2 🗆 N
a or 2		10e. Street and Number 1175 Professional Court		10f. Zip Code 21740		Og. Citizen of What Co USA	untry ?
ns 23	Funeral	11 Marital Status 12. Was Decedent Ever in	in U.S. 13.		ic Origin? (Specify Yes or No- exican, Puerto Rican, etc.)	14. Race - Ame	
from "natural", or items 23a or 28a-f show re McClinal Examiner must be notified at	by	Armed Forces? 1 Never Married 2 Married 1 Yes, 2 No 1 Yes, Give Year or Dates:			ecify:	Black, Whit	nite
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Hygi other	To Be Co	17. Father's Name (First, Middle, Last) Charles Weigand		18.	Mother's Name (First, Middle, Marie Brown	Maiden Surname)	
snd Me	F	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ing Address (Street and N	lumber or Rural Route Number	r, City or Town, State, 2	Zip Code)
alth a		Richard C. Schmidt - son			Beaufort, N.		
of He If item		1 Burial 2 XCremation 3 Bemoval from State		matory or other place)		20c. Location - City or	
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permit, rages i aring should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		21. Signature of Forneral Service Licensee			n Blvd., Hager	FUNERAL HON stown, Md.	
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attending	Physician/Medlcal	IF FEMALE: 23b. Was decedent pregnant in the past 12 moonts? 1	Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of del Month	ivery Day Year
the character and the	by Ph	Part II. Other significant conditions contributing to death but not	I - 70 "	1	Part I. 23e. Did to	bacco use contribute to	the cause of death
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as been signed by the	ple	Dely drapin			perfor 1 ☐ Yes	med? death? 2☑No 1☐Yes	2 No
	Completed			Other	Place of Death (Check only of		aiful
	Be	25. Was case referred to medical examiner?	αΠΕΒ/O-++		✓ Mursing Home 5 ☐ Resid	ow injury occurred	спу)
is certifica	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 27. Manna of Death 28a. Date of Injury	2 ER/Outpatie	of 28c. Injury at	28d. Describe h		
is certifica director, p	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 27. Manne of Death 1 Natural 5 Pending 2 Accident Investigation	28b. Time				
is certifical	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 27. Manner of Death 1 Natural 5 Pending (Month, Day Yea	28b. Time of Injury At home, farm, s	of 28c. Injury at Work? M 1 ☐ Yes	2 🗆 No	treet and Number or Ri	ural Route Number,
dospita or Autoinung Friystolen. A hours after death. Funeral Director: After this certifics ely filled in by the funeral director, s	Certification: To Be	examiner? Saminer Hospital: Inpatient	At home, farm, socify)	of 28c. Injury at Work? M 1 Yes treet, factory, office	2 No 28f. Location (S City or Tow	treet and Number or Ri n, State) ause(s) and manner as	s stated.
dospital of Attending Physician: The law required hours after death. Funeral Director: After this certificate has been selligied in by the funeral director, page 2 should	To Be	examiner? Sexaminer Pospital: Impatient Impat	At home, farm, socify)	of 28c. Injury at Work? M 1 Yes treet, factory, office th occurred at the time, divestigation, in my opinio 29c. License nui	2 No 28f. Location (S City or Tow ate and place, and due to the on, death occurred at the time, on	treet and Number or Rin, State) sause(s) and manner at late and place, and due	s stated. b to the cause(s) h, Day, Year)
ang Pnysician: 1. After this certifications director, p	edical Certification; To Be	examiner? Saminer Hospital: Inpatient	At home, farm, socify)	of 28c. Injury at Work? M 1 Yes treet, factory, office th occurred at the time, divestigation, in my opinio 29c. License nui	2 No 28f. Location (S City or Tow ate and place, and due to the c	treet and Number or Rin, State) sause(s) and manner at late and place, and due	s stated. b to the cause(s) h, Day, Year)

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NE A. S	TKI	T = State Registrar	State of Marylan	-	artment o <i>rtificate d</i>		Mental Hy	giene Reg.No.	05	35632
		1. Decedent's Name (First, Middle, Las	1)				2. Date of De Month		Voor	3. Time of Death
Physi /Med		B DISTINA A. STRADIS					OCTOBE	R 15,	, 2005	0615 p ^м
Exam		4a. Facility Name (If not institution, give			4b. City, Tow	n, or Location of Deat	1	1	ounty of Deat	
		FAIRLAND NURSING 8	REHAB CENTER		SILVE	R SPRING			VTGOME	RY
Funera Directo	-	5. Social Security Number 6. Se 577–20–7182	7. Age (In yrs. 83	last birthday) Yrs.	Months Da		8. Date of Bi (Month, Di Apr 8,	1922	9. Birti <i>Co</i> V ir t	nplace (State or Foreig untry) Sinia
P		Usual Residence of Decedent								
If I I I I I I I I I I I I I I I I I I	١,	10a. State 10b. County		y, Town or Lo	ocation					10d. Inside City Limits
Ba-f	Disposito.	Maryland Prince	Georges U	nivers	ity Par					
or 2		10e. Street and Number			10f. Zip Cod	de		10g. Citize	n of What Co	untry?
ath w	0	3806 Calverton Dr				782		ŲS.		
tems	To a constant	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent If Yes, specify (of Hispanic Origin? (S Cuban, Mexican, Puert	pecify Yes or No o Rican, etc.)	0- 14	 Race - Ame Black, White 	
or I	ŭ,	1 Never Married 2 Married	1 ☐ Yes 2X No If Yes, Give		1 ☐ Yes 2 ☐ 🕱	No Specify:		s	pecify:	
hours	7	3 Widowed 4 □ Divorced	Year or Dates:	1000	C - 11 - 10	•		100 100	Whit	
n 72		15. Decedent's Ed (Specify only highest grad	de completed)	(Give	dent's Usual Od kind of work do DO NOT use re	one during most of wor	rking	160. Kind	of Business/	industry
withiu	100	Elementary/Secondary (0-12)	College (1-4or 5+)	1	etary			Le	~ n 1	
Hygint, Int.	3			Seci	etaly_	18. Mother's Nar	ne (First, Middle			
d be ontal	å						stelle		,	
d Me	F	19a. Informant's Name/Relationship (7	voe Print)	19h Maili	ng Address (St	reet and Number or Ru				in Code)
d2s d2s than than treu		Justine Anne Smit				Ct, Centr				
Heal Heal		20a. Method of Disposition	20b. P	lace of Dispe	osition (Name o	f	Date		ation - City or	Town, State
parkilliore, invary failure 2 12 13 10000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparkment of Health and Mental Hygiene. Important: If time 27 is marked other than "natural; or Items 23e or 28e-1 show any injury or other treumatic event, tra Medical Evanting must be notified at	2	1 ☐ Burial 2 ☐ Cremation 3 ☐	Hemoval from State		matory or other		± 10 2			
it. P.		*4 □Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen				ematory Ocuderess of Facility Hi				
Derm Perm Depa Impo	ouce	Ola . 1	De la							г ноше ng, MD 209(
		23a. Part 1. Enter the disease, or cong	plications that caused the deat						L BPIII	Approximate
		shock, or heart failure. List only Immediate Cause (Final	ne cause on each line.						7	Interval Between Onset and Death
Physicia /Medica		disease or condition resulting in death)	a ! yfetteuse		work	wtie (and	iovuseu	elar 1	21 Stust	
Examine			Dute to (or as a conseq	uence of):						
	*	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conseq	uence of):						-
ped nsit	-	cause. Enter Underlying Cause (Disease or injury								
ou, se executed sian and surial-transit	1	that initiated events resulting in death) Last	C. Due to (or as a conseq	uence of):						
be ex sician a burial		-								
ficate by physic as the bu			d							
. DOX OO/ON death certificate be e attending physicia of for use as the but		IF FEMALE: 23b. Was decedent pregnant in the past 12 gronths? 1	23c. If yes, outcome of pregna					23	d. Date of del	verv
atter of for u		in the past 12 months?	1 Live birth 2 ☐ Fete 4 ☐ Pregnant at time of d		⊒Ectopic pregn ⊒ Other (specif				Month	Day Year
the cy the		9 Unknowh	9□ Unknown							
uires that the der	Č		ontributing to death but not res	ulting in the u	underlying cause	e grven in Part I.	23e. Did	tobacco use	e contribute to	the cause of death?
ords requires een sign hould be		a a contraction of the contracti					1 🗆	Yes 2 🗙	No 3□Pr	obably 4 Unknown
							24a. Wa	s an	24b. Were au	topsy findings available
The law The has b							auto perf	ormed?	death?	topsy findings available completion of cause of
	(25. Was case referred to medical				00 01	12 Yes	2 No	1X Yes	2 No
OI VILA Physician: this certific ral director,		a examiner?	Hospital:	FD/0	-1 00 004	26. Place of De			7 0	" CCIENTE
hy his	1	1 XYes 2 No 27. Manner of Death	1 Inpatient 2	28b. Time of		4 □ Nursing F Injury at Work?	1ome 5 ☐ Res 28d. Describe			city) SCENE
ding h. Afte fune		Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury		Work? 1 ☐ Yes 2 ☐ No		,,		
JIVISION Lor Attending after death. Director: After		3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	ome, farm. st					Number or Ru	ıral Route Number,
after Dire		4 Homicide determined	building, etc. (Special	(y)				wn, State)		
DIVISION C ospital or Attending P hours after death. uneral Director: After t ly filled in by the funera		29a. Certifier 1 Certifying Ph	ysicien: To the best of my kno	owledge, dea	th occurred at the	ne time, date and place	a, and due to the	cause(s) a	nd manner as	stated.

State Registrar 31. Date filed (Month, Day, Year)

OCT 19 2005

29b. Signature and title of centifier



29c. License number

OCME

29d. Date signed (Month, Day, Year)

17, 2005

OCTOBER

			1 - For State Registrar	State of Mar	yland / Dep <i>Ce</i>	artment of F rtificate of	lealth and Death		jienen ()5	35633
*	Dhysisi	7.03 2.03	1. Decedent's Name (First, Middle,	Last)				2. Date of Dear Month	th Day	Year	3. Time of Death
	Physici /Medic		Betty F.	Stallone				0ctober			6:00 a M
	Examin	er	4a. Facility Name (If not institution,	give street and number)		4b. City, Town, o	r Location of Deat	h	4c. Coun	ty of Death	1
		Ž.,	Holy Cross Hos	_			Spring			ntgon	
	Funeral		5. Social Security Number 6	Sex 7. Age ((In yrs. last birthday,	Months Days	If Under 24 Hrs Hours Min.		Year)	9. Birth	nplace (State or Foreign Intry)
*	Director		577-26-3303		83 Yrs.			June 5,	1922	Was	shington, DC
	pug *		Usual Residence of Decedent 10a. State 10b. County		IOc. City, Town or L	ocation					10d. tnside City Limits
	sho	5			,,						1 ☐ Yes 2 ☑ No
	28e-f	Director	Maryland Mont 10e. Street and Number	gomery	Wheaton	10f. Zip Code		1	Og. Citizen of	What Co.	intar?
	with a or		2721 Randolph R	5.co				'	17		antry :
	eath mari	era		12. Was Decedent Ev	er in IIS 13	20902 Was Decedent of H	lienanio Origin2 (9	Specify Ves or No-		USA	ican Indian,
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "netural", or iteme 23s or 28e-f show other traumatic event, the Mudical Examinational Landing all	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?		If Yes, specify Cubi	Specify:	to Rican, etc.)	BI	ack, White	, etc.
ŏ	thor.	ed	15. Decedent's	Education	16a. Dece	dent's Usual Occup	pation		16b. Kind of	Business/le	ndustry
15	n 7	Completed	(Specify only highest Elementary/Secondary (0-12)		life.	e kind of work done DO NOT use retire	during most of wo. d)	rking			
7	ad with /giene. er the	E	12	Coltege (1-4or 5+)		redit Col	llector		Retai	7	
	filled Hygid other	Be C	17. Father's Name (First, Middle, La	ist)		10010 001		me (First, Middle,			
<u>ھ</u>	lid be ked ked lc ev	To B	Randolph Clark				Minnie	Groves			
Maryland	2 should be to and Mental I is marked or raumatic eve		19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ing Address (Street			r, City or Town	ı, State, Zi	ip Code)
	1 and 2 Health a tem 27 to		David Stallone/	Son	4317	Morningw	ood Driv	e. Olnev	. Marv	land	20832
<u>ق</u>	s 1 a f Hez f Hez othe		20a. Method of Disposition		20b. Place of Disp	osition (Name of matory or other plan		Date	20c. Location	- City or T	own, State
D D	age of the control		1 反 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			lemorial Par	3-	ober 21 005	Rockvi	lle,	Maryland
Baltimore,	permit. Pages 1 Department of H Importent: If Ite ony Injury or ot		21. Signature of Funeral Service Li		r ²	2. Name and Addre	ess of Facility.	Funeral	Home	Inc	
	au z v u		James 2	Colo						pring	, MD 20901
			23a. Part1. Enter the disease, or co shock, of heart failure. List or	omplications that caused the nly one cause on each line	ne death. Do not en	iter the mode of dyir	ng, such as cardia	c or respiratory arr	est,		Approximate Interval Between Onset and Death
	Physician		tmmediate Cause (Final disease or condition	_a PNEU	MONIA						DAYS
4	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):						
	Examiner.		Sequentially list conditions,		LOINTESTI	INAL BL	REDING				HOURS
	ס א	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):						
	nd rrans	am	Cause (Disease or injury that initiated events resulting in death) Last	0.	RTENSION						YEARS
Ö,	e exe ian a urial-	ŭ	resulting in death) Last	Due to (or as a	consequence of):					- 1	
8760,	cate be executed physician and the burial-transit	dical	•	d							
Θ		Med	IF FEMALE:					111100	1		
Вох	that the death certiff ed by the attending detached for use as	by Physician/Me	23b. Was decedent pregnant	23c. If yes, outcome of 1 Live birth 2		Ectopic pregnancy	,			ate of deliv	,
о. П	edea he at	sici	in the past 12 months? 1 Yes 2 No	4☐Pregnant at tii 9☐Unknown	me of death 5	Other (specify)			IV	lonth	Day Year
<u>Р</u>	at the	hy	9 Unknown								
Ś	8		Part II. Other significant condition	s contributing to death but	not resulting in the	underlying cause giv	ren in Part I.		bacco use co es 2 □ No		the cause of death?
Vital Record	w requir been si should	Completed						24a. Was a	ın 24b	. Were aut	opsy findings available
Re	yslcien: The lav is certificate has director, page 2	m						autops	med?	prior to co death?	ompletion of cause of
a		e C	25. Was case referred to medical					1 Yes	_	1 U Yes	2)xI No
₹	Physicien: this certific ral director,	8	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	0 (EB/O	nt 3 DOA Oth	ar	ath (Check only on			
	F = 10	٠ <u>۲</u>	27. Manner of Death	28a. Date of Injury	28b. Time o	FIL 3L DOA	4 Nursing F	dome 5 Reside			iry)
on	ding Phy th. After thi funeral	ţ	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Day	Year) Injury	Wor	rk? Yes 2∐No				
S	deal deal ctor: y the	fica	3 ☐ Suicide 6 ☐ Could no	t be 290 Place of Injur	y - At home, farm, st			28f. Location (Si	treet and Nun	ber or Rui	ral Route Number,
Division of	after Dire	Certification:	4 ☐ Homicide determin	building, etc.	(Specify)	, , , , , , , , , , , , , , , , , , , ,		City or Town			
_	Hospitel or Attenc 24 hours after death Funerel Director: tely filled in by the		29a. Certifier 1 Certifying	Physician: To the best of	my knowledne, dea	th occurred at the fir	me, date and place	and due to the o	ause(s) and n	nanner as	stated.
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	edical	one) Linear Strain Control	taminer: On the basis of e	xamination and/or it	ivestigation, in my	pinion, death occi	urred at the time, d	ate and place	, and due t	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		1	29c. Licens	e number	2	9d. Date sign	ed (Month,	, Day, Year)
	/		D. Vulwanne	ditys red	7 70	20	13464	0	CTOBER	-18.	- 2005
Tr	1)5		30. Name and address of person w	*				1.70			
(ソ		VILLAMADITYA !				SUITE 208	, ROCKY	LLE, 1	4D-22	0852
· V	Sta	te	31. Date filed (Month, Day, Year)		s Signature						
18	Regist	ar	OCT 19 2	005	A. Phom	NE S					

State of Maryland / Department of Health and Mental Hygiene 05 For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) OCTOBER 77, 2005 1:28 PM **Physician** STANLEY HARVEY SCHWARTZMAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** CARROLL WESTMINSTER CARROLL HOSPITAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) MARCH 27, 1929 Days Hours NEW YORK XX M 2□ F 76 Vrs 057-22-1700 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County itams 23a or 28a-f show i Haalti and Mental Hygiene. Itam 27 is marked other than "natural", or Itams 23a or 28a-f shov other traumatic event, the Modicul Exercities must be notified at 1 ☐ Yes 2 📆 🛠 🕏 SYKESVILLE Director MARYLAND CARROLL 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number UNITED STATES 21784 7309 SECOND AVENUE Pages 1 and 2 should be filed within 72 hours after death vent of Heath and Mental Hygiene.
ant: if itam 27 is marked other than "natural", or Itams 23, ury or othar traumatic event, the Medical Event in er must Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 XX es 2 □ No If Yes, Give Year or Dates: KOREA XXNever Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2√No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) HIGH SCHOOL TEACHER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RHODA BERMAN JOSPEH SCHWARTZMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 19a. Informant's Name/Relationship (Type, Print) LAW&MEDIATION CENTER LLC ROBIN L. WEISSE/ATTORNEY WESTMINSTER, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 10/25/2005 20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ Removal from State GARRISON FOREST VETERANS CEMETERY OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility Dep Imp any ii MYERS-DURBORAW FUNERAL HOME, P.A. 91 WILLIS STREET, WESTMINSTER, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician geumon.a /Medical Due to (or as a consequence of): **Examiner** 16 montra Sequentially list conditions, if any, leading to immediate any first linder, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical as IF FEMALE: esn 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death Division of Vital Records, P.O. the 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ 1 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ctrointestine autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Dispase 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🗐 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death

1 Natural
2 ☐ Accident 28b. Time of Certification: tha Hospital or Attending I hin 24 hours after death. the Funaral Director: After Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier within 7 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AM Westminster MD Kus 31. Date filed (Month, Day, Year) State OCT 19 Registrar

State of Maryland / Department of Health and Mental Hygiene 15 35635 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death OCT. 15^{Day}2005^{Year} **Physician** SCOTT WILLIAM 4:26PM W /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner P.G. PRINCE GEORGE'S HOSPITAL CHEVERLY If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. MAY 1941 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months 1₩ 2□F 64 579 50 4709 Yrs. WASH. D.C. Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County item 27 is markad other than "naturel", or items 23a or 28a-f show other traumatic event, Ite Madical Examiner must be multified at 1 XYes 2 No D.C. WASHINGTON Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 36th ST., N.E. 121 20019 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 □XYes 2 □ No

If Yes, specify Cuban, Mexicar

1 □ Yes Give Year or Dates: 1960/1963

13. Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexicar 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) INK MAKER FED. GOVT. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mental and Mental JOHN SCOTT GENEVIEVE HARRISON 19a. Informant's Name/Relationship (Type, Pr GLADYS SCOTT/WIFE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 121 36th ST., N.E. WASH. D.C. 20019 item 27 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o ō cemetery, crematory or other place MT. OLIVET CEM. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 10 /22/05 WASH. D.C. 22. Name and Address of Facility WATSON F. H. 21. Signature of Funeral Service Licensee 3435 14th ST., N.W. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FATAL CARDIAC ARRHYTHMIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of):
CORONARY ARTERY DISEASE **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the esn IF FEMALE If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown þ signed b Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ €R/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 XNo inis 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospitel or Attending Natural 5 Pending 1 Yes 2 No investigation death. 2 Accident after death Director: 6 Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide CertifyIng Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. within 2 To the 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certify 2/240 10-17-05 who completed cause of death (Item 23a) (Type, Print) WASHINGTON, DC N. 1011 . Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 2 0 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 5 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** October 1340 17 2005 Sample Sr. Joseph Lee /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner YENINSULA REGIONOS 54/1864/14 Medical Wicomico If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Oct.24 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months Maryland 1 M 2 ☐ F 1940 214-36-5718 64 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b County 10a State or 28a-f ahow s 1 and 2 should be filed within 72 hours after death with the Maryla if Health and Mental Hygiene. If the state of 28a-1 ashow other traumatic event, Item 72 is marked other then "natural", or Items 23a or 28a-1 ashow other traumatic event, Item Maxical Examine must be notified as 1 ☐ Yes 2 No Director Maryland Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code U.S.A 21801 1510 Jersey Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify δ 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Barber Barber 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Melvin Lee Sample Sr. Maudie Sample 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traum once. 1510 Jersey Rd.Salisbury, Md.21801 Arnetta Sample (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 105 Hebron, Md. 4 ☐ Donation 5 ☐ Other (Specify) Springhill Mem.Garden 21. Signature of Funeral Service Licensee Stewartdorfuffeltal Home Hladyo B: Stewars 821 West Rd.Salisbury, Md.21801± 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death STND ROME Immediate Cause (Final -IEPA TO RENAL 2 DAYJ **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner LIVER YEARS CIRRHOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine HEPATITIS 15 YEARS attending physician and for use as the burial-transit The law requires that the death certificate be executed CHRONIC that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) certificate hes been signed by the a rector, page 2 should be detached i 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DISEASE CHRONIC KIDNEY 1 Yes 2 1 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performed? 2 No 1 Yes r death. octor: After this certifica by the funeral director, p Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 28c. injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 Matural 5 Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

within 24 hours after deat To the Funeral Director:

State Registrar

31. Date filed (Month, Day, Year) OCT 2 0 2005

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. SHIRAZI, M.D. PENINSULA REGIONAL MEDICAL CENTER. MD 21801 32. Registrar's Signature

ORIGINAL

14 6 962 OCTOBER 18, 2005

			For State Registrar	State of Maryl		rtment of Health tificate of Deat	th	Reg. No.	5	356	
70.	Physici /Medic		1. Decedent's Name (First, Middle, Last) Paul Rober	t Toney, Jr	•		2. Date of D Month Octob	Day er 26, 20	Year 005	3. Time of 8:40	Death P M
*	Examin Funeral Director		4a. Facility Name (If not institution, give s 38533 Ted Drive 5. Social Security Number 6. Sex 172–38–2770		yrs. last birthday) 59 Yrs.	Avenue If Under 1 Year If Under Months Days Hour	der 24 Hrs. 8. Date of E		Mary 9. Birthp	lace (State o	r Foreign
	ס	or	Usual Residence of Decedent 10a. State 10b. County		City, Town or Lo	cation			1	0d. Inside Cil	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f ehow enty injury or other traumatic event, Ire Medical Examinant be notified at once.	rai Directo	10e. Street and Number 38533 Ted Drive		Avenue	10f. Zip Code 20609		10g. Citizen of V	d St	ates	
036	ours after de rai', or items Exeminar m	by Funerai	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	 12. Was Decedent Ever Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 		Was Decedent of Hispanic f Yes, specify Cuban, Mexi I ☐ Yes 2 X No Spec		Bla	e-Americk, White,	etc.	
Maryland 21215-0036	within 72 ho iene. • than "natui ine Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12	cation completed) College (1-4or 5+)	(Give life. L	dent's Usual Occupation kind of work done during n DO NOT use retired) Plant Mechanic	nost of working	16b. Kind of B		,	
/land 2	wild be filed Mental Hygi arked other atic event,	To Be C	17. Father's Name (First, Middle, Last) Paul Robert To:	ney, Sr.		18. Mc	others Name <i>(First, Midd</i> jorie Mayerhoe		пө)		
	l and 2 sho fealth and im 27 is ma her trauma		19a. Informant's Name/Relationship (Ty Charlotte Elaine	Coney/ Wife		B Ted Drive,					
Baltimore,	artment of Hartment of Hartment: If Ite ortant: If Ite injury or other		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	emoval from State	cemetery, crem etropolita	natory or other place) n Crematory Name and Address of Fa	October 27, 2005	Alexandri			
Ba	Dep Per		23a. Part 1 Enter the disease, or complishock, or heart failure. List only or	Tardiner cations that caused the	Ma P.	ttingley-Gardin O. Box 270, Leo	er Funeral Hom nardtown, Mary	1and 20650		Approximate Interval Bets	
68760,	Physician physician and physician and physician approximately transit is the paral-transit.	edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		nsequence of):	el Nic	6 Concer			Onset and C)eath
P.O. Box 6	The law requires that the death certif ite has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		1	te of delive onth		fear
	w requires that been signed b should be deta	þ	Part II. Other significant conditions con	ntributing to death but no	t resulting in the u	nderlying cause given in Pa		d tobacco use con			
tal Reco	in: The law r ificate has be or, page 2 sh	e Completed	25. Was case referred to medical			26 Di	24a. Wi au pe 1 Yes	topsy normed? 2 No	Were auto prior to co death? 1 ☐ Yes	psy findings impletion of c	available ause of
Division of Vital Records,	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification: To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Autural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Yea		nt 3 DOA Other 4 f f 28c. Injury at Work? M 1 Yes 2	Nursing Home 5 Ae 28d. Describ		red		har
Div	Hospital or At 24 hours after 6 Funeral Directers of the 14 hours after 6		4 Homicide determined 29a. Certifier 1 Certifying Phy	28e. Place of Injury - building, etc. (S	pecify) y knowledge, deatl	h occurred at the time, date vestigation, in my opinion,	City or 1	own, State)	anner as s	tated.	
S	To the Ho within 24 To the For completel	Medical	29b. Signature and title of certifier	and manner stated.	L	29c. License numb	er	29d. Date signe			
~)	8,		30. Name and address of person who of Dr. David M. Federle	24035 Three	Notch Road	d. Hollywood. M	aryland 20636				
4	Sta Regist	ate rar	31. Date filed (Month, Day, Year) OCT 2	32. Registar's 5	signature	South					

		•	For State Registrar	State of Maryland		ment of H icate of I		vientai Hy	glenze	5	35638	
11	- Fy	_	Decedent's Name (First, Middle, Last)				2. Date of De		Year	3. Time of Death	
¥	Physicia /Medic		Catherine Elizab	eth Tavlor					r 8, 200		11:00 PM	
	Examin		4a. Facility Name (If not institution, give		41	. City, Town, or	Location of Death		4c. County	of Death		
			1322 Locust Trail	7 Ago //ours	a of hirthday) If	Lusby Under 1 Year	If Under 24 Hrs.	8. Date of Bir		ert (County	
1	Funeral Director		5. Social Security Number 6. Se 1579–46-0209	7. Age (In yrs. I. ☐ M 2▼F 69		onths Days	Hours Min.	(Month, Da	26, 1936		place (State or Foreign ntry) ryland	
			Usual Residence of Decedent					March 4	20, 1330			
	how	_	10a. State 10b. County	10c. City	, Town or Locati	on				1	10d. Inside City Limits 1 □Yes 2X No	
	Be-f	octo	MD Anne Aru	ndel Co. Lot	hian	0 T 0 1			10g. Citizen of V	1/h-1 C		
	a or 2	Funeral Director	10e. Street and Number			10f. Zip Code					ind y :	
	Jeath	era	68 Third Street	12. Was Decedent Ever in U. Armed Forces?		20711 Decedent of H	ispanic Origin? (Span, Mexican, Puert	pecify Yes or No	U.S.A	e - Americ	can Indian,	
920	•it. Peges 1 and 2 should be filed within 72 hours after death with the Maryland seriment of Health and Mental Hygiene. ortent: if item 27 is marked other than "natural", or items 23a or 28a-f show ortent: if item 27 is marked other than "natural", or items 23a or 28a-f show ortent: if item 27 is marked other than "natural".	by Fun	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	Armed Forces? 1		s, specify Cuba Yes 2 <u>∏</u> No	In, Mexican, Puerto Specify:	o Rican, etc.)		k, White, White		
S O	72 ho	Completed by	15. Decedent's Edi (Specify only highest grad	ucation de completed)	(Give kind	's Usual Occup	during most of wor	king	16b. Kind of B	usiness/In	dustry	
2	within ene. then "	mple	Elementary/Secondary (0-12)	College (1-4or 5+)		NOT use retired	1)	·	D-4-37	C 4		
2	e filed within al Hygiene. I other then '	ပိ	10 17. Father's Name (First, Middle, Last)		Clerk		18. Mother's Nam	ne (First, Middle	Retail Maiden Suman		re	
and	d be f	To Be	Raleigh Courtney				Sarah I	Dalton				
Š	should be nd Mental i marked c	F	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailing A	ddress (Street	and Number or Ru		er, City or Town,	State, Zip	Code)	
	and 2 ealth a n 27 is		Michael K. Taylor	(Son)	7815 H	amoton 1	Way, Owin	ngs. Mar	vland 2	0736		
	Peges 1 an nent of Heal ant: If Item? ary or other		20a. Method of Disposition 1 X Burial 2 Cremation 3	20b. P	lace of Disposition emetery, cremate	n (Name of	o) Octob	per 14,	20c. Location -	City or To	own, State	
ij	Peg Iment tent: I		4 Donation 5 Other (Specify) Mar	yland V			005			Maryland	
Ball	permit. Peg Department Importent: f any injury o		21. Signature of Interior Victors 22. Name and Address of Facility Lee Funeral Home Calvert, I 8125 Southern Maryland Blvd., Owings, MD 20									
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	one cause on each line.							Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	a Metastatic disease, presumed lung malignoney munths Due to (or as a consequence of): Respiratory failure								
	Examiner		Construction the line and distance	Respirator			weeks					
	p #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (dr as a consequénce of):								
	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Chronic Due to (or as a consequence)) bythu	the	Luny 1	ligeose			years	
68760,	cate be execut physician and the burial-tran	aiE					,					
687	_ ()	edicai		0.								
Вох	eath certif attending for use a	N/U	23b. was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy						23d. Date of delivery		
-	a death	Physician/M	in the past 12 months? 1 Pyes 2 No	4 Pregnant at time of do		her (specify)			Mo	nth	Day Year	
P.0	that the de ed by the detached	Phy	9 ☐ Unknown Part II. Other significant conditions co	entributing to death but not res	ulting in the unde	rhina cauce au	on in Part I	23e Did	tobacco use cont	ribute to t	he cause of death?	
ords,	The law requires that the death certive has been signed by the attending tage? should be detached for use a	ted by	atrial fibrill						Yes 2 □ No	/		
Vital Records,		Completed						24a. Was auto perf 1 Yes	opsy ormed?	prior to co death?	opsy findings available ompletion of cause of	
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Dea			Brot	her's	
of	Phys rthis raldii	. To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatient	3 DOA	4 Nursing H	lome 5 Res	how injury occur	er (Specii red	Residence	
O	th. After funer	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	28c. Injur Wor M 1 🗆	k? Yes 2 □ No		,,			
Division	tal or Attendits a after death. al Director: A ad in by the fu	Certification;	3 Suicide 6 Could not be determined			factory, office		on (Street and Number or Rural Route Number, Town, State)				
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical C		ysician: To the best of my kno niner: On the basis of examina and manner stated.								
	To the within To the	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signe			
			> M, mg)		060	390		10/13	120	205	
	ኸ		30. Name and address of person who	completed cause of death (Item	n 23a) (Type, Pri	nt))	6				
	J		TOEEB JABE 31. Date filed (Month, Day, Year)	completed cause of death (Item 2 00 H 95 32. Registry's Signa 2 2005 Screen	PITAL R	0, 1	RINCE	FREDG	= NICK,	MD	20678	
2	Sta Registi		OCT 1	2 2005) May	. K	draites						

			State of Maryland / De State of Maryland / De State of Maryland / De State of Maryland / De Registrar	partment of Health and Nertificate of Death	Mental Hygier	2005 No.	35639					
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Joshua Brack Terrill	2. Date of Death Month Day Vear October 26, 2005 5:00 A								
	Examin		4a. Facility Name (If not institution, give street and number) Lions Manor Nursing Home		4c. County of Dea	ıth						
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 486-30-6865 1) M 2 I F 76 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month Day, Yea	9. Bi	thplace (State or Foreign curity) SSOUTI					
	yland Now		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits					
	he Mar 28a-f st	ector	MD Allegany LaVale				1 XYes 2 No					
	23a or 3	ral Dir	10e. Street and Number 1135 Broddock Road 1135 Braddock Road	10f. Zip Code 21502	10g. (Citizen of What C USA	ountry?					
, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, I're Medical Examinational Le motified at ance.	d by Funeral Director	11. Marital Status 1 □ Mever Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 M No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto □ Yes 2√2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:						
	hin 72 h a. an "natu Medical	Completed	(Specify only highest grade completed) (Gi	edent's Usual Occupation re kind of work done during most of work DO NOT use retired)	ing 16b.	16b. Kind of Business/Industry						
	filed wil Hygien ther th		17. Father's Name (First, Middle, Last)	Osterer Upholste	rer Fu	rniture						
	ould be Mental arked o	To Be	Simeon Fred Terrill		(Carlisl		ill					
	and 2 shi ealth and n 27 is m	- Chillian	Claire B. Berlendy 113	iling Address (Street and Number or Rur 5 Braddock Rd,	LaVale, i							
Baltimore,	Pages 1 ment of Hi ant: ff iter ury or oth		20a. Method of Disposition 1 □ Burial 2 XCremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify)	position (Name of emator or other place) n Crematory oct.	28,05 U1	Location - City or niontow						
Balt	permit. Departi Import any inj once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Ha 1302 National H	fer Fune:	ral Ser ale, MD	vice, PA 21502					
	Physician /Medical		23a. Parti Enter the disease, of complications that caused the death) Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Such as Cardiac or respiratory arrest, Interval Consett a disease or condition resulting in death) Approximately a consett a									
	Examiner	Examiner	Due to (or as a consequence of): Sequentially list conditions.				l					
V	outed od ransit		if any, leading to immediate cause. Due to (or as a consequence of): Cause (Disease or injury that initiated events									
58760,	icate be executed physician and s the burial-transit	edical Ex	resulting in death) Last Due to (or as a consequence of):									
P.O. Box 68	ath certif ttending or use as	Physician/Medi		□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	livery Day Year					
	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco		o the cause of death? robably 4 □Unknown					
al Records,		e Completed	25. Was associated to modified			prior to	utopsy findings available completion of cause of					
of Vital	Phyaicie this certi al directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati	ent 3 DOA Other: 4 Nursing Ho	me 5 Residence	6 □Other (Spe	cify)					
ouo	Attending Phyaicien: r death. ector: After this certific. by the funeral director.		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time Injury		28d. Describe how in	jury occurred						
Division of	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	28f. Location (Street: City or Town, Sta	Location (Street and Number or Rural Route Number, City or Town, State)							
	To the Hospital or within 24 hours afte to the Funerel Dir completely filled in	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the causered at the time, date a	(s) and manner as and place, and due	s stated. a to the cause(s)					
	To th within To th comp	Me	29b. Signature and title of certifier	29c. License number	j	Date signed (Mont	h, Day, Year)					
•	0		30. Name and address of person who completed cause of death (Item 23a) (Typ	^	30 Oc	tober	26,2005					
	Sta	to	Sunil-Grupta, MD 625 Kg 31. Date filed (Month, Day, Yeal) 32. Agistrar's Signature	ent Ave. Cum	berland	I, MD	21502					
	Registr	_	31. Date filed (Month, Day, Yeal) 32. Registrar's Signature	Suli .								

Physicia		1. Decedent's Name (First, Middle, L		and / Depa 11-2-05 Cei	· · · · · · · · · · · · · · · · · · ·	2. 0	ate of Death		3. Time of Dear	
		Shane Randall	Truitt		O	Day Year 28, 2005				
/Medic Examin		4a. Facility Name (If not institution, g			4b. City, Town, or Loc			4c. County of De		
	8	8901 Whaleyville	Rd.		Bishopsvi	TTC-	1	Worceste	r	
Funeral			1371 M 20 E	yrs. last birthday)		lours Min. (/	ate of Birth Month, Day, Ye	ar) 9. B	irthplace (State or For Country)	
Director		213-27-3453	25	Yrs.		10)/31/19	79	MD	
¥		Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or Lo	ocation				10d. Inside City Li	
e page	ō	MD Worce	ctor	Whaley	,illa				1 Tyes 2	
28a-	Director	10e. Street and Number	ster	wilaley	10f. Zip Code		10g.	Citizen of What C	Country?	
3a or	0	8901 Whaleyville	Rd		21872			JSA		
m 2 2	Funerai	11. Marital Status	12. Was Decedent Ever i	in U.S. 13.	Was Decedent of Hispa	nic Origin? (Specify	Yes or No-	14. Race - Arr		
nal Hygiene. od other then "natural", or liems 23s or 28s-f ehow event, its Modical Exactinat mast be notified at	by	1X Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:		If Yes, specify Cuban, M 1 ☐ Yes 2 🕱 No S	лехісап, Рието Нісаі Бресіfy:	n, etc.)	Specify: V		
natur Ical	ted	15. Decedent's (Specify only highest of		16a. Dece	dent's Usual Occupation kind of work done during	n na most of working	16b	. Kind of Busines	s/Industry	
. 5	ρie	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired)	ig most of working				
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d oth	Be	17. Father's Name (First, Middle, La	st)		18.	. Mother's Name (Fire		,		
Meni arke atic	2	Randy Truitt				Billie Je				
and Mental I		19a. Informant's Name/Relationship	(Type, Print)		ng Address (Street and					
ealth m 27		Randy Truitt			Old Ocean					
I Ita		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3	Removal from State		matory or other place)	Date		. Location - City o		
ant: ury o		4 ☐ Donation 5 ☐ Other (Spec		Dale Cer	,			naleyvill		
Department of Health and Menta Important: If Itam 27 is marked eny injury or other traumatic events.		21. Signature of Funeral Service Lic	T Ralbut		2. Name and Address o				ral Home	
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Vedical		disease or condition resulting in death)	a Due to (or as a con		NSMOTWOU	100 00 11	עונטו			
aminer			550 (0) 40 40 40 00	1004001100 01).						
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State of Maryland / Department of Health and Mental Hygien For State Registrar 35641 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 22,2005 01:17 AM James Harrison Twyman, Jr. October /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cily, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington County If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F Director December 25 1943 West Virginia 220-40-0139 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "naturel", or itame 23a or 28a-f show other traumatic event, the Modical Example visit be notified at Director 1X Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 nent of Heatth and Mental Hygiene. Int: If Item 27 is marked other then "naturel", or Itams 23a or 2 Completed by Funeral 12 S. Walnut Street 21740 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Artist Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 James H. Twyman Sr. Dorothy Jenkins Twyman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Jean Sharkey (friend) 304 Williamson Ave. Greencastle Pennsylvania 17225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Department of Important: If any injury or once. Greenlawn Memorial Pk. 10-25-05 Williamsport Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee eiglas 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Bladder monte Lance /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Chaito (or as a consequence of) To the Hospital or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 TNo 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? page 2 this certificate 2 No 1 Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death Check only one Hospital: Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

Muleur

32. Registrar's Signature

McCornects

30. Name and address of perso, who completed cause of death (Item 23a) (Type, Print)

O.

31. Date filed (Month, Day, Year)

041667

10.22.05

nedical Campis Brierstown MP

Jenny Tou 05-07126 CT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

35642 State of Maryland / Department of Health and Mental Hygiene () 5

1.	Physician /Medical Examiner
	Funeral Director
100	Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryk Department of Health and Mental Hygiene. Importants if Item 27 is marked other then "natural", or Items 23a or 28a-f shot any injury or other traumatic event, the Medical Examinar maint be notified all once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	1. Decedent's Name (First, Midd.	e, Last)						2. Date of De	eath Day	Year	3. Time of Death		
ian ical	Jenny	Yen-I	ung	To	ou			Octobe		0 2005	12:20 P		
ner	4a. Facility Name (If not institution 8907 Liberty L	n, give street and n			4b. City, Town, Potoma	С				County of Death			
	5. Social Security Number 505 54 0044	6. Sex 1 □ M 2x⊡x F	7. Age (In yrs. 70	last birthday) Yrs.	If Under 1 Yea Months Day	-		8. Date of Bi (Month, D. March	ay, Year)	Col	plece (State or Foreign Intry) hina		
ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Mon	tgomery		y, Town or Lo	ocation						10d. Inside City Limits		
i Director	10e. Street and Number	8907 Liberty Lane						10f. Zip Code 20854					
by Funeral	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	12. Was De Armed I ned 1 _ Yes If Yes. (cedent Ever in U. Forces? 5 2 No Bive Dates:		Was Decedent of If Yes, specify Cu	Hispanic (uban, Mexic	can, Puerto	pecify Yes or No Rican, etc.)	y Yes or No- an, etc.) 14. Race - American Indian, Black, White, etc. Specify: Asian				
Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+				dent's Usual Occ kind of work don DO NOT use reti	e during m red)	ost of work		6b. Kind of Business/Industry				
o Be Co	17. Father's Name (First, Middle, Ming Tsung Hung		Tang Hua Chao Chemist US Government EPA 18. Mother's Name (First, Middle, Maiden Surname) Tang Hua Chao										
	19a. Informant's Name/Relations William Wei-Hs			8907	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8907 Liberty Lane Potomac, Maryland 20854								
	20a. Method of Disposition 1 Burial 2 Cremation 4 Onation 5 Other (3 21. Signature of Funeral Service	pecify)	n State	Lincol	2. Name and Add	tory ress of Fac	11/1	es Rina	Bre aldi	Funeral	Maryland Home		
	2 a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Approximate Interval Betwoenset and Do not enter the mode of dying, such as cardiac or respiratory arrest, and Do not enter the mode of dying, such as cardiac or respiratory arrest, and Do not enter the mode of dying, such as cardiac or respiratory arrest, and Do not enter the mode of dying, such as cardiac or respiratory arrest, and Do not enter the mode of dying, such as cardiac or respiratory arrest, and Do not enter the mode of dying, such as cardiac or respiratory arrest, and Do not enter the mode of dying, such as cardiac or respiratory arrest, and Do not enter the mode of dying, such as cardiac or respiratory arrest, and Do not enter the mode of dying, such as cardiac or respiratory arrest, and Do not enter the mode of dying, such as cardiac or respiratory arrest, and Do not enter the mode of dying, such as cardiac or respiratory arrest, and Do not enter the mode of dying, such as cardiac or respiratory arrest, and Do not enter the mode of dying, such as cardiac or respiratory arrest, and Do not enter the mode of dying, such as cardiac or respiratory arrest, and Do not enter the mode of dying, such as cardiac or respiratory arrest, and Do not enter the mode of dying, such as cardiac or respiratory arrest, and Do not enter the mode of dying, such as cardiac or respiratory arrest, and Do not enter the mode of dying, such as cardiac or respiratory arrest, and Do not enter the mode of dying, such as cardiac or respiratory arrest, and Do not enter the mode of dying, such as cardiac or respiratory arrest, and Do not enter the mode of dying, such as cardiac or respiratory arrest, and Do not enter the mode of dying, such as cardiac or respiratory arrest, and Do not enter the mode of dying, such as cardiac or respiratory arrest, and Do not enter the												
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Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown	23c. If yes, o 1 □ Live 4 □ Pre 9 □ Uni	□Ectopic pregnancy 23d. Date of deliven Month D						very Day Year				
þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribution										the cause of death?		
Completed	24a. Wa autu per 1 A Yes									utopsy prior to completion of cause of death?			
Be	25. Was case referred to medical examiner?	Hospital:				N		h (Check only					
atlon; To	27. Manner of Death 1 Anatural 5 Pendi 2 Accident invest	28a. Dat	Inpatient 2 e of Injury onth, Day Year)	28b. Time o Injury	f 28c. In			ome 5 Res 28d. Describe		☑Other (Spec r occurred	hyScene		
Certification:	3 Suicide 6 Could 4 Homicide detern	nined 288. Pla	ce of Injury - At he Iding, etc. (Specif		reet, factory, office	е			Street and wn, State)	Number or Ru	ral Route Number,		
Medical		ng Physician: To t Examiner: On the and ma											
Σ	29b. Signature and title of certific	Dref Harels	na		29c. Lice OC	nse numbe ME	ər		Octo	signed (Month ber 22,	2005		
	30. Name and address of person		all mi)	Print) 111	Penn	Stree	et Bali	imore	e, Mary	land 21201		
tate trar	31. Date filed (Month, Day, Year OCT 2	8 2005	Flogistrar's Signa	ature	as the								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Delores Marie Turner 3:30 Рм October 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Day, Year 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F 74 386-26-0646 Yrs. Director 8, 1931 Michigan Usual Residence of Decedent filed within 72 hours aftar death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f ahow 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours attar death with the Marylar nent of Heatth and Mental Hygiena.
ant: If item 27 is marked other than "natural", or Items 23a or 28a-f ahov ury or other traumatic avant, the Medical Examir arminal be notified at Funeral Director Maryland Anne Arundel 1 Yes 2 □ No Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7101 Bay Front Drive #306 21403 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ☐Yes 2\CXNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Š+ Violin Consultant Board of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Gimbosa Elena Baditoi ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Turner/husband 7101 Bay Front Drive #306 Annapolis, MD 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or once. Baltimore Crematory 10/18/2005 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service I 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester Annapolis, MD las 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** hronic Respiratory disease or condition resulting in death) /Medical Examiner Jeuromus cula Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed ettending physician and Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 3 Probably 4 Onknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 Tyes Certification: To 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1-Natural 5 Pending To the needs after death.

To the Funeral Director: After the further of the furt investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 585 ddress of person no completed cause of death (Item 23a) (Type, Print) AAMO lexo 2001 Medical Parkway Annapolis, MD 21401 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Va	alerie	Pea	arle Vasilas Please Amend item#2	Type or Pr	int in B	lack_In	delible	lnk.	Ensu	ıre Al	I Copies	Are	Legibl	e.		
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Д.			1- For Amend #11 Registrar HCHD, al	, 10-20-	-05, F	Cel	tificate	of E	Death			Reg. No.	000	•	000	
	Physicia	an.	Decedent's Name (First, Middle, La.	st)							2. Date of De		, y,	aar	3. Time of	Death
	Physician Valerie P. Vasilas										Octobe	r 15	, 20Č	5	6:01	Ам
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п	Funeral		5. Social Security Number 6. S	6ex 7.4 □M 2 [2]F	Age (In yrs. la.	st birthday) Yrs.	If Under 1 Months I	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	h y, Year)		Birthpla Count	ace (State d ry) jinia	or Foreign
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	nand ow		10a. State 10b. County		10c. City,	Town or Lo	cation							10	d. Inside C	ity Limits
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	death with the Maryland me 23a or 28a-f show Emest be notified at	Funeral Director	4412 Ridge Ave	Apt #2			212	27					USA			
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9	or its		1 Never Married 2 Married	1 □ Yes 2√2 If Yes, Give			Tes, specify		Specify:		nican, etc.)		Black, \	White, e	tc.	
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S	or A after Direction by	ertit	4 Homicide determined	building, e	etc. (Specify)	10, 1aiiii, s(ie	el, raciory, o	ince		-	City or Tow	n, State)	i ivumber o	r murai r	HOUIÐ NUMI	<i>)er</i> ,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 1 ☐ Certifying Ph	ysician: To the bes	st of my knowle	edge death	occurred at t	the time	date an	d place	and due to the	ause(s)	and mann	1 2F 5t-1	ed	
	24 h 24 h Fur etely	edicai	(Check only 2 X Medical Examone)	niner: On the basis and manner s	of examinatio	n and/or inv	estigation, in	my opi	nion, deal	th occurre	ed at the time, o	ause(s) a late and p	place, and	due to ti	he cause(s)	,
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	-		30. Name and address of person who	completed cause of	death (Item 2	(3a) (Type 1	Print) 111	D ₀	nn C	troc	+ Dol-	imar	o M-	w-1	- J 01	201
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State of Maryland / Department of Health and Mental Hygiene 05

35645 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Oct 26, 2005 Vanscov Marion Agnes 4:40 pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Devlin Manor Nursing Home** Cumberland Allegany If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Sep 16, 1914 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) **Funeral** Months Days Director 219-03-8298 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours efter death with the Maryland nent of Heatth and Mental Hygiene. Int: If them 27 is marked other than "natural; or flems 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at 10d. Inside City Limits MD Allegany Cumberland Director Yes 2□No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 10301 Christie Road, NE 21502 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ☐ Yes 2☐ No f Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 □ Yes Ž□ No Specify: Specify: white þ If Yes, Give Year or Dates: 3 ☐ Widowed X ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Therapy Nursing Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Edwin Keech Mary Agnes (O'Neil) Keech 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Aldridge niece 3562 Evitts Creek Road Bedford PA 15522 other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite 1 ☐ Buriat 2 X Cremation 3 ☐ Removal from State 10/27/2005 Cresaptown Scarpelli Funeral Home, P.A. 4 ☐ Donation 5 ☐ Other (Specify) MD 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 r the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, eart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Alledical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Physician/Medical Examiner or Attending Physicien: The law requires that the death certificate be executed use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Division of Vital Records, P.O. Box 68760, that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 → No Be Completed by funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 1 Yes 2 Ho 1 LI Yes 2 LI No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4⊟Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending death. 2 Accident investigation 1 TYes 2 No To the Funeral Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 - Homicide within 24 hours a To the Funerel D 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) Alleri ha D17565 Oct. 27, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anthony Bollino, M.D.; 922 National Highway; LaVale, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 2 2005 Glow It footh Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental HygieRe

			1 - For State Registrar	State of Mar		artmen <i>rtificat</i>			nd M		iepe ()	5	35646
	Physici		Decedent's Name (First, Middle, Last, Sophia R.	Wudkewych	l.			-		2. Date of Deat Month	Day 13/200	Year 5	3. Time of Death 7:35 A M
	/Medic Examir		4a. Facility Name (If not institution, give Future Care Chesa	street and number)			Town, or	Location of		107	4c. County		
	Funeral Director		5. Social Security Number 6. Security Number 200–42–0657	7. Age (In yrs. last birthday, 99 Yrs.	If Under Months	1 Year Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Birth (Month, Day, 03/21/	^{Year)} 1906	Cou	place (State or Foreigr ntry) ISY lvani a
	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Itams 23a or 28a-1 show ant, the Medical Exertine trinust be troitly of at	Director	10a. State 10b. County MD Anne Aru 10e. Street and Number 1148 Summit Drive	ndel	Oc. City, Town or L Annapol	1.S	Code			11	0g. Citizen of USA		10d. Inside City Limits 1 ☐ Yes 2 🛣 No
-0036	Phours after death stural', or Itams 20	ed by Funeral		12. Was Decedent Evi Armed Forces? 1 ☐ Yes 2 🌠 No If Yes, Give Year or Dates:		Was Deced	lent of Hi cify Cuba 2 🔯 No	n, Mexican, Specify:	in? (Spe Puerto		14. Rad Bla	ck, White, iy: Whit	te
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ryland	2 should be fill and Mental H Is marked off	To Be	17. Father's Name (First, Middle, Last) Stanley Vilary 19a. Informant's Name/Relationship (Ty	una Drint)	105 14-15		(6)	Rose	<u> </u>	(First, Middle, M (unknown	1)		
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ı	F ≯ F ŏ		30. Name and address of pyrson who co	Mpleted cause of death	M (Item 23a) (Tyre		D	50	72	5 /	0-1	4-	2005
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2: 0 2005	32. Registrar's	of Vet	191	ns H	wy/	U.	lersv	· lle	M	01146

State of Maryland / Department of Health and Mental Hygiene 15 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Oct. 19, Day 2005 Year Wilson Monroe Whaley, Jr. 3:30 а м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7580 Easton Club Drive Easton Talbot If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, July 21, 1 5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Director Yrs. 213-16-3763 85 1920 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. Count 10d. Inside City Limits or 28a-f show r than "natural", or Items 23a or 28a-f shov tte Modical Experient sust be notified at 1 Pes 2 □ No Funeral Director Maryland Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7580 Easton Club Drive 21601 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ fes 2 ☐ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 à Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event. If a Mexicon way injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) 10 Organic Chemist Science Chemistry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wilson Monroe Whaley, Sr. Pearl Douthirt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Buffardi Whaley/Spouse 7580 Easton Club Dr., Easton, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State MidShoreCremationCenter 10/19/2005 Cambridge, MD * 4 □ Donation 5 □ Other (Specify) 21. Some ure of Funer per ice Licensee Mid Shore Cremation Center, P.O. Box 2272 Hudson Rd., Cambridge, MD 2161 Twork 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOTROPHIC LATERAL Schenosis **Physician** disease or condition resulting in death) 10 MONTH /Medical Due to (or as/a consequence of Examiner Sequentially list conditions, if any leading immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy certificate 20 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After the 27. Mann eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Al Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by 4 Homicide hours after filled in within 24 hours a To the Funeral D 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ludwig J. Eglseder, III, M.D., 503 Cynwood Drive, Easton, MD 31. Date filed (Month, Day 2 1 2003 Registrer's Signature State Registrar

			1 - For State Registrar	State of M	aryland / I	Depar <i>Certi</i>	tment ificate	of H	ealth a Death	nd M	ental Hy	gierie Reg. No		3	5648
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	/Media		Martha Ja								Oct.	19	200		12:50P [™]
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	Funeral		Snow Hill Nursi 5. Social Security Number 6. Se		ge (In yrs. last bii	rthday)	Snow If Under 1	Year	If Under 2		8. Date of B	irth	orcest 9.E		(State or Foreign
	Director		217-03-5921	□M 2 K) F	91	Yrs.	Months	Days	Hours	Min.	Dec.8,	1913		Country) MD	,
	p ,		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow		41			••••				10-1	nside City Limits
	faryla shov	ŏ													Yes 2X No
	28e-i	Director	MD Wicomi 10e. Street and Number	CO	Pit	tsvi	IIe 10f. Zip (Code				10a Citi	izen of What		
	3a or	0	7240 Sixty Foot R	d. Apt.	18			850				US		,	
	death	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Wa			panic Orig	in? (Spe	cify Yes or N Rican, etc.)		14. Race - Ar		idian,
9	after or ite		1 Never Married 2 Married	1 ☐ Yes 2X☐X If Yes, Give			os, speci		Specify:	rueno	nicari, etc.)		Black, W SpecifyWh		
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ylaı	should be nd Mental r marked c umetic ev	To	J. Staton Littlet	on					Lau	ra (unknow	n)			
Maryland 21215-0036	C1 00 - 10		19a. Informant's Name/Relationship (T)	ype, Print)								-	r Town, State		
e, P	1 and Health Bm 27 ther tr		Betty Jones 20a. Method of Disposition		20b. Place o				oot R		Apt. 2	_	cation - City		1d.21850
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ords, P	w requires that the been signed by th should be detache	þ	Part II. Other significant conditions co	ntributing to death b	out not resulting i	in the unde	erlying car	use give	n in Part I.			tobacco u Yes 2	se contribute ☑No 3☐		use of death?
Division of Vital Records,	The law ate has b page 2 sl	Completed									24a. Was auto perf 1 ☐ Yes		prior to death	completi	ndings available ion of cause of No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Cthou			(Check only				
on of	ding h. After fune	tion: To	1 Yes XXNo 27. Manner of Death 1 (XNatural 5 Pending investigation	1 ☐ Inpation 1 ☐		utpatient Time of Injury	3 DOA	c. Injury Work	4AC INUI	2	ne 5 ☐ Res 8d. Describe		S □Other (Sp y occurred	ecify)	
Divisi	i i i i i	Certification:	3 Suicide 6 Could not be determined	28e. Place of In building, et	ury - At home, fa c. <i>(Specify)</i>	arm, street	t, factory,	office		2		(Street and wn, State)	d Number or I	Rural Rou	te Number,
	HOS Funda ely	edicai	29a. Certifier (Check only one) 1 ☑ Certifying Phy 2 ☐ Medicel Exemi	sicien: To the best iner: On the basis o and manner st	f examination an	e, death od nd/or inves	ccurred at	t the time n my opi	e, date and nion, death	place, a occurre	nd due to the d at the time,	cause(s) date and	and manner place, and d	as stated, ue to the o	cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	.0			29c.	License	number				e signed (Mo		/
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) <u>.</u> +	1,3		30. Name and address of person who co	Empleted cause of o	death (Item 83a)	(Type, Pri	int)	- ,	M	D	2185	-/			
	Sta Registr		31. Date filed (Month, Day, Year)		ar's Signature	Spa	ule	,				/			

ORIGINAL

State of Maryland / Department of Health and Mental Hygiege 05 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** October <u>3:55</u>pm[™] Walter Sparling Wilkerson 18, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Months Days Hours Director 53 Sept. 24, 1952 212-64-2372 Maryland Usual Residence of Decedent r 28a-f ehow r notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery Poolesville Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Item 27 is marked other then "natural", or iteme 23s or other traumatic event, the Modical Examinar must be 20837 19505 Wootton Avenue United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) 12 Welder Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental Hisant: If Item 27 Is marked other Be 2 Frederick Lee Wilkerson Katherine Sparling Jenne 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Colleen Mary Wilkerson (Spouse) 19505 Wootton Avenue, Poolesville, MD 20837 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Important: If It any Injury or o 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 10/19/05 Alexandria, Virginia 22. Name and Address of Facility DeVol Funeral Home permit. 21. Signature of Fundral Service 10 East Deer Park Drive Gaithersburg, MD 20877 Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or bear lattice. List only one cause on each line. Immediate Cause (Final disease or condition MUCANDIAL Priysician 1/NUTES resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequent of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the ettending pt d for use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the e 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an certificate has birector, page 2 s 1 Yes Hospitel or Attending Physician: Be After this certification 25. Was case referred to medical 26. Place of Death (Check only of Hospital: 1 Inpatient 2 VOutpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 0 Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier mo completed cause of death (Item 23a) (Type, Print) 30. N Center Drive Rockville Md. 20850 Medical SKOUR 90 51. Date filed (Month, Day, Year) 32 Registrar's Signature State Joseph) OCT 20 Registrar 2005

		4	For State	State of Man	land / De	partment of Certificate of	Health and I <i>Death</i>	Mental Hy	giene	35650
	8	6	Registrar Decedent's Name (First, Middle, Last)					2. Date of De	ath	3. Time of Death
	Physicia /Medic		DANDY HANK WO	1G				Octobe	er 12, 20	05 8:19 A ^M
	Examin		4a. Facility Name (If not institution, give				or Location of Deat	h	4c. County of	
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-37	Funeral Director				53 Yrs	Months Davs	Hours Min.	May 3,	1952 V	9. Birthplace (State or Foreign Country) Nashington D.C.
	pu k		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town o	r Location				10d. Inside City Limits
	Manyli f sho	o	Md. Montgomen			Spring				1 □Yes 2 No
	r 28a	irect	10e. Street and Number	- 9	DILVEL	10f. Zip Code			10g. Citizen of Wh	nat Country?
	23a o	ai D	1505 Milestone Dri	Lve			20904		United S	tates
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Departient of Health and Mental Hyglene. Importants if Item 27 is marked other than "natural", or Items 23a or 28a-f show amy njury or other traumatic event, the Modical Exeminar must be multilised at annexe.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 ☑ No	oan, Mexican, Puer	pecify Yes or No to Rican, etc.)	Black,	- American Indian, , White, etc. Asian
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2	led wi lygien her th	Con	17. Father's Name (First, Middle, Last)	2	Tec	hnical Wr	T .	no /First Middle	Militar Maiden Sumame	y Contractor
Maryland	d be fi	o Be	Hale Wong					e Yee	, Maiden Surrame,	,
ary	shoul and M s marl umati	ပ	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. N	lailing Address (Stree	t and Number or Ru	ıral Route Numb	er, City or Town, Si	tate, Zip Code)
	and 2 ealth a n 27 is			ster)		7 Langport			0 :	
Baltimore,	Pages 1 ment of H ant: If Iter ury or oth		20a. Method of Disposition 1 □ Burial 2 🖔 Cremation 3 □ P 4 □ Donation 5 □ Other (Specify)	temoval from State		isposition (Name of crematory or other place) olitan Cre	m. 200		Alexandr	
Balt	Departi Departi Import any inj ang inj		21. Signature of Funeral Septice Licens	by		22. Name and Addi				g, Md. 20877
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687	tificate g phys as the	edical								
Division of Vital Records, P.O. Box	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of p 1☐Live birth 2☐ 4☐Pregnant at tim 9☐ Unknown	Fetal death	3 Ectopic pregnants 5 Other (specify)	Ç y		23d. Date Monti	,
ds, P	uires that signed bi Id be deta	d by Pr	Part II. Other significant conditions con Metable			ne underlying cause g	iven in Part I.			oute to the cause of death?
Recoi	The law requir te has been si vage 2 should l	Completed						24a. Was auto perfo	psy pri prmed? de	ere autopsy findings available or to completion of cause of ath? Yes 2 □ No
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_	Physician: r this certifica ral director, i	2	1 Yes 2 No	fospital: 1 Inpatient 28a. Date of Injury	ÉR/Outpa 28b. Tim	ALIBERT SEL DOA			dence 6 Other	
on	ding th. After funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Ye		ry W	ork? Yes 2 \ No	280. Describe	now injury occurred	•
Divisi	al or Attending after death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (, street, factory, office)	28f. Location (City or To	Street and Number wn, State)	or Rurai Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical C	29a. Certifying Phy (Check only one)	sician: To the best of mer: On the basis of ex and manner stated	amination and/o	leath occurred at the or investigation, in my	time, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and manr date and place, an	ner as stated. d due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	()		1 -	se number	9		(Month, Day, Year)
£	541		Dura M	1. Jugge	MID	10	5992	(10-	12-05
			30. Name and address of person who co				. Daal	11a M	20050	
- 5	Sta	ite	Dr. Aaron Snyder M			Center Di	. ROCKV	rrre, MO	. 20030	
-	Registi		OCT 2 0 20	195 Banks	Signature	COSME!				

State of Maryland / Department of Health and Mental Hygiene 0.5For Stata Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** October 18, 2005 8:50 a Walton, Thomas Joseph /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Callvert Huntingtown 3105 Holland Cliff Road If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1**∑**M 2□ F Yrs. Feb 11, 1942 Wash., D.C. 63 Director <u>219-38-4215</u> Usual Residence of Deceden 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County 28e-f ehov the Medical Examiner must be notified at 1 ☐ Yes 2 No Huntingtown Directo Calvert MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5 20639 USA 3105 Holland Cliff Road permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene Important: if Item 27 is marked other than "naturel; or items 23a any julury or other traumatic event, the Micdical Examiner reserved. Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-!! Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2X No Specify: Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) steamfitter, HVAC mechanic HVAC construction 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rita Colliflower Gertrude Harden Sr. Charles Walton. ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3105 Holland Cliff Rd., Huntingtown, MD Nancy L. Walton, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 10-19-2005 Alexandria, VA 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 20736 Rausch Funeral Home, P.A., Owings, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner physician and s the burial-transit The law requires that the death certificate be executed Box 68760 use as IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Year Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. be detached 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 Ø No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one Be examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 MR Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funeral Director: A 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) in by 4 Homicide Hospitel filled t 💢 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29b. Signature and title of certifie who completed cause of death (Item 23a) (Type, Print) 1050 Solomons Is. Rd., N., Prince Frederick, MD 20678 Emad Al Banna, M.D. 31. Date filed (Month, Day, Year) 32. Registra Signature

DHMH 17 Rev 1/2001

State

Registrar

2 0 2 0 0 5

			1 - For State Registrar	State of Maryland /	Department of H Certificate of I	lealth and M <i>Death</i>		₽ • 0 5	35652
	Physic /Medi	cal	Decedent's Name (First, Middle, Last	LLIAMSON	4b City Tours	r Location of Death	2. Date of Death Month	37 20	3. Time of Death A M
	Exami Funeral Director	1 1	5. Social Security Number 6. Se	ICE AT LAKE 7. Age (In yrs. last b)	E SALL	BURY	8. Date of Birth (Month, Day,) March 2,	4c. County of	9. Birthplace (State or Foreign Country) Marvland
			Usual Residence of Decedent 10a. State 10b. County MD Carol	ine 10c. City, Tow	m or Localion			1743	10d. Inside City Limits 1 ☐ Yes 2X☐ No
	death with the Maryland ms 23a or 28a-f ehow	ai Director	10e. Street and Number 6530 Reliance	···	10f. Zip Code	.632		g Citizen of W	hat Country? States
9800	ours after al', or ite	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Spe in, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)		- American Indian, K, White, etc. White
21215-0036	ed within 72 hours giene. or then "natural", the Medical Ext.	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired Seamstress	during most of workir f)	ng	Sports	siness/Industry SWear
Maryland	hould be file d Mental Hy marked oth matic event	To Be	17. Father's Name (First, Middle, Last) Fletcher Alber 19a. Informant's Name/Relationship (Ty			18. Mother's Name Ruby Man	rie And	rews	
Baltimore, Ma	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur eny injury or other traumatic event, tra Medical ADGE.		Emerson William 20a. Method of Disposition 1 Rurial 2 Cremation 3 F 4 Donation 5 Other (Specify)	nson/Spouse 6	530 Relian bisposition (Name of ry, crematory or other place) mery Cemet	ce Rd.,	Federa	1sburg	g, MD 21632 City or Town, State
Balti	permit. Departm tmporta eny inju		21. Signature of Funeral Service Licens	98	22. Name and Address 216 N. Mair	s of Facility Fra n St., Fed	mptom leralsbur	Funera	1 Home P A
58760,	Physician pad pad physician and physician and physician and physician and physician are the physician and physician are the physician and physician are the	dical Examiner	23a. Part1. Enter the disease, or compleshock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	co/on (g, such as cardiac or	respiratory arresi	t.	Approximate Interval Between Onset and Death
P.O. Box 6	The faw requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 Yes 28 No 9 Unknown	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date Monti	of delivery h Day Year
Records, P	w requires that been signed t should be det:	ρ	Part II. Other significant conditions cor	tributing to death but not resulling in	n the underlying cause give	n in Part I.	23e. Did tobac	~ /	oute to the cause of death?
Vital Reco		Completed	25. Was case referred to medical				24a. Was an autopsy performed	d? pri	ere autopsy findings available or to completion of cause of ath? Yes 2
of Vi	Q & D	To Be	examiner?	ospital:	tpatient 3 DOA Othe	26. Place of Death C 4 ☐ Nursing Hom		e 6 Other	(Specify)
n o			27 Manner of Death Natural 5 Pending		Time of 28c. Injury		3d. Describe how		
Division	ten leat tor: the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - Al home, fa building, etc. (Specify)	M 1 🗆 Y	es 2 🗆 No	Bf. Location (Stree City or Town, S	et and Number State)	or Rural Route Number,
	To the Hospitel or Al within 24 hours after or To the Funeral Directompletely filled in by	Medical	one)	icien: To the best of my knowledge er: On the basis of examination and and manner stated	d/or investigation, in my op	inion, death occurred	nd due to the caus d at the time, date	e(s) and mann and place, an	ner as stated. d due to the cause(s)
	To To		29b. Signature and title of certifier 30. Name and address of person who co	-COM	29c. License D2	_			Month, Day, Year) 5 7/802
7/2	Sta	te	David E. Cavell MO 31. Date filed (Month, Day, Year)	Couste/ Hospie 32 Registrar's Signature	PO BOX 1	737 Se	Asby	MO	21802
	Registr		OCT 2 5 2005	Dogway De	Brand's				

			I _ Side	artment of Health and Mental rtificate of Death		5 35653
			Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of	Reg. No.	3. Time of Death
	Physici	an		Month	Day	Year
5	/Medio Examin		Joseph Patrick Walters, Sr. 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	19, 200 4c. County	
	CXAIIII	eı	Calvert Memorial Hospital	Prince Frederick		Calvert
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8, Date of	f Birth	Birthplace (State or Foreign Country)
	Director		212-68-5139 1\\ \frac{1}{2}\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		7/1956	MD
	D >		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lot			
	shov	'n		Scation		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	28a-f	Director	MD Calvert	North Beach	ton Object of M	
	a or i			10f. Zip Code	10g. Citizen of V	
	ns 23	era	4043 8th Street 11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Specify Yes o	US or No. 14 Bace	SA e - American Indian,
	fter d	Funeral	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Blac	k, White, etc.
8	urs a	by	3 ☐ Widowed 4 ☑ Divorced	1 ☐ Yes 2 X No Specify:	Specify	White
Ŏ	within 72 hours after death with the Maryland ene. than "natural", or itams 23s or 28s-f show Ita Madical Examinar must be notified at	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working	16b. Kind of Bu	
2	thin 7	nple	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		
7	ygien ygien ner th	Co		y Equipment Operato		nstruction
gu	be till Had ott	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mi		
Maryland 21215-0036	hould d Mer marka martic	임	Sidney Raymond Walters 19a. Informant's Name/Relationship (Type. Print) 19b. Mailin	Mary Joseph		
Ma	d 2 sl th an 17 is r traur		1,7,7,7	ng Address (Street and Number or Rural Route N		
ē,	Heal Heal tam 2		Joseph P. Walters, Jr./Son 4110 20a. Method of Disposition 20b. Place of Dispo	osition (Name of Date		City or Town, State
<u>o</u>	ages ant of it: if ii		1 Buriai 2 M Cremation 3 Hemoval from State	ake Crem. 10/20/05		ille, MD
altimore,	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinat must be notified at ODGs.			2. Name and Address of Facility Raymon		
ä	Ded Person	kt, i	1 (Word	PO Box 430, Dunkirk	. MD 20'	.n., r.A. 754
			23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician			tepatic Failure		Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	Coparie Tarion		
L	Lxammer	<u>.</u>	Sequentially list conditions, b. HeDatitis			
	bed isit	nine	if any, leading to immediate Due to (dr as a consequence of): cause. Enter Underlying Cause (Disease or injury			
	xecul and al-trar	Examiner	that initiated events c			
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached tor use as the burial-transit	dical E	d			
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Вох	eath certitic attending p	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □	∃Ectopic pregnancy	23d. Date	e of delivery
	e deal	Physician/Me	1 Yes 2 No	Other (specify)	Mor	nth Day Year
<u>о</u> .	that the de ned by the a detached t	Phy	9 🗆 Onknown	100		*
Š,	w requires that been signed I should be det	by	Part II. Other significant conditions contributing to death but not resulting in the u	PICI		ibute to the cause of death? 3 Probably 4 Unknown
Records,	requ	Completed	District of the state of the st	The second second		
3ec	has l	mpl	Dianeis Meilitus, Pailea L	14-11-001-373-10011	utopsy	Vere autopsy findings available rior to completion of cause of eath?
	ician: Th certificate rector, pag		Hepatic Encephalopathy Pe	2 Ficarditis 10 Y	es 2 No 1	☐ Yes 2☐ No
Ĭ	sicia certi irecto	o Be	25. Was case referred to medical examiner? 1 — Yes 2 No Hospital: 1 Inpatient 2 — ER/Outpatier	26. Place of Death (Check on the state of Doath) Other: 4 \(\) Nursing Home 5 \(\) F	1	- (0
o	g Phys er this eral di	n; To	27. Manner of Death 28a. Date of Injury 28b. Time of	" 3 DOX 4 THUISHING TOTHE 3 TH	ibe how injury occurre	
<u>o</u>	death. ctor: After y the funer	atlo	1 ØNatural 5 ☐ Pending (Month, Øay Year) Injury 2 ☐ Accident investigation	M 1 Yes 2 No		
Division of Vital	I or Attano after death Diractor: I in by the	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)		on (Street and Numbe Town, State)	or Or Rural Route Number,
	ital or ris aft ral Di					
	Hosp 24 hou Funa tely til	edical	29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, deat (Check only 2 ☐ Medical Examiner: On the basis of examination and/or in	h occurred at the time, date and place, and due to vestigation, in my opinion, death occurred at the ti	the cause(s) and mar me, date and place, a	nner as stated. nd due to the cause(s)
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely tilled in by the funeral director, page	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed	(Month, Day, Year)
	⊬ ≱ ⊢ 8		Person C SIN ANA	D 511-53		9-2005
			30. Name and access of person who completed cause of death (Item 23a) (Type,	Print) GYAN C SURF	NA	, , , ,
	L		5851. Deale Churchton Roa	d Deale MD.	2075	1
	Sta		31. Date filed (Month, Day, Year) OCT 2 0 2005	1		,
	Registr	ar	OCT 2 0 2005 Blown &	Hower		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year BARBARA Α. WARFIELD October 29, 11:50 A.M 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 4072 Jacksonville Road Crisfield Somerset If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1□M 257F 218-50-1467 Yrs. Director June 18, 1948 Maryland Usual Residence of Decedent the Maryland 10a State 10h Counts 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic avant. It a Medical Examinar must be notified at Maryland Somerset Crisfield Directo 1 Tyes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 4072 Jacksonville Road 21817 U.S.A. death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 15 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 TM Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 2 Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) (Specify only highest grade completed) 2 should be filed within 7 and Mental Hygiene.

is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Chesapeake Rehab. Transportation Department 10 Center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Calvin Jones, Sr. Estelle Marie Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun William W. Warfield, III (HUSBAND) 4072 Jacksonville Road- Crisfield, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Salisbury Crematory 1 4 □ Donation 5 □ Other (Specify) 10/31/05 Salisbury, MD 21. Signature eral Service Lie 22. Name and Address of Facility Bradshaw & Sons Funeral Home Robert H. Bradshaw, 306 W. Main St.- Crisfield, MD 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sq varous Physician Cell Corcinon 7000 /Medical Due to (o as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): Box 68760. physician Physician/Medical the use as t IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Dav 4☐Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death Check onl one examiner Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Hospital or Attending 5 Pending 1 Natural death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: 6 Could not be 3 Suicide 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To tha Funeral C 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 030690 Oct. 31, 2005 30. Name, and address of person who completed cause of death (Item 23a) (Type, Print) , M.O. MERTIN 145 E. Geroll St. Felisbury E 31. Date filed (Month, Day, Year) 32. Segistrar's Signature State NOV 0 2 2005 Registrar

			1 - For State Registrar	State of M	aryland / D	epartmen Certificat	t of H e of L	ealth an Death	d Me		iene g. No.)5	35655
	Physic		1. Decedent's Name (First, Middle,		1.77777	7 MG				. Date of Dear Month	th Day	Year	3. Time of Death
	/Medi Exami		ANDRE 4a. Facility Name (If not institution,	LEROI give street and number	WILLI		Town, or	Location of D		octobe		2005 ity of Death	1107AM
			Shady Grove A	Adventist	Hospita	al Ro	ockv	ille					omery
10 m	Funeral				ige (In yrs. last birth	day) If Under	1 Year Days	If Under 24 I Hours N		Date of Birth		9 Birth	place (State or Foreign
	Director		Usual Residence of Decedent	TOSINI ZELF	36 Y	rs.			J	an.16	,1969	Wa	Sh, DC
	/land		10a. State 10b. County		10c. City, Town	or Location							10d. Inside City Limits
	Many 1-1 sh	tor	MD Monte	omery		Rockvi	ille						1 ∰Yes 2 □ No
	or 284	Director	10e. Street and Number			10f. Zip	Code			1	0g. Citizen o	f What Cou	ntry?
	ath wi	ai	545 Elmcroft	Blvd #1	0109		20	850			U	.S.A	•
	within 72 hours atter death with the Maryland ene. then "natural, or items 23e or 28e-f show ite Madical Exeminer must be notified at	Funeral	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S.	13. Was Deced	lent of His	spanic Origin?	? (Specif	y Yes or No-		ace - Ameni ack, White,	
36	or l	by F	1	If Yes, Give		1 ☐ Yes 2		Specify:		, ,	Spec		lack
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Z	should be and Mental in marked o	2	Cosmo Willi						nie		ınson		
Maryland	C/ c0 = c4		19a. Informant's Name/Relationshi			Mailing Address							Code)
	1 and Health em 27		Cosmo William 20a. Method of Disposition	is- rather		Box 1			S H.				
nor	Pages ment of I		1 ☑Burial 2 ☐Cremation 3 4 ☐Qonation 5 ☐Other (Spe	B □Removal from State	20b. Place of D cemetery, Gate o				/21/		20c. Location		
Baltimore,	permit. Page Department Important: If any njury or once.		2). Signature of Funeral Service Li		Gate 0	22. Name and		1			Fune	ral I	oring,MD Iome, P.A.
ä	Dep Imp any	0	(oaus	Levele	Sul			1		. 5-3-3			e, MD 2085
- 3			23a. Part 1. Enter the disease, or c shock, or heart failure. List of	omplications that cause	d the death. Do not	enter the mode	of dying	, such as card	diac or re	espiratory arre	est,	V 1 1 1 C	Approximate
	Physician		Immediate Cause (Final disease or condition		TIC SHO							9	Onset and Death
	/Medical Examiner		resulting in death)	а.	s a consequence of)								4110015
	LAdiffile	L	Sequentially list conditions,	U	UBITUS U								ionths
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9	death certificate be executed e attending physician and id tor use as the burial-transit	ledi		.									
Box	eath certifi attending I for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Petal death	3 □Ectopic pre	anancu.				23d. D	ate of delive	эгу
о П	at the dea by the at tached to	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant a 9□Unknown		5 Other (spe					М	onth	Day Year
<u>т</u>	hat thid by detach	Phy	9 ☐ Unknown Part II. Other significant condition	e contribution to doubt h									
Kecords,	The law requires that the te has been signed by th age 2 should be detache	d by	Renal Failu	re	out not resulting in tr	ie underlying ca	iuse giver	n in Part I.		_			ne cause of death?
ö	w require been si should b	ete	D						-		s 2 No		. 10
Ě	he lav e has ige 2	ompleted	Diabetes Me	Ilitus					-	24a. Was an autopsy perform		Were autor prior to con death?	psy findings available inpletion of cause of
_	0 1	0 0	25. Was case referred to medical					00 Di/ D		1 Yes 2	No.	1 🗌 Yes	2 % No
	× .5 0	To B	examiner? 1 ☐ Yes 2 ∰No	Hospital:	ent 2 ER/Outpa	tient 3 DO				heck only one 5 🗌 Resider		nor (Casal	
	ding Phys h. Atter this funeral di		27. Manner of Death Natural 5 Pending	28a. Date of Inju	ıry 28b. Tim		lc. Injury a Work?	at	28d.	Describe hov	v injury occu	rred	/
<u> </u>	Attending r death. sctor: Atter by the fune	satic	2 ☐ Accident investigat	ion	, , , , , , , , , , , , , , , , , , , ,	м		s 2□No					
DIVISION	or Atl fter d Sirect in by	Certification:	3 Suicide 6 Could no 4 Homicide determine	ad 286. Place of In	jury - At home, farm tc. <i>(Specify)</i>	, street, factory,	office		28f.	Location (Stre	et and Num State)	ber or Rural	l Route Number,
1	pital ours a orai [1	200 Contine to Continue	25i.i					_ i				
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely tilled in by the	edical	29a. Certifier 1 Certifying (Check only one) 1 Medical Ex	Physician: To the best aminer: On the basis of and/manner st	r examination and/o	eath occurred a r investigation, i	t the time in my opir	, date and pla nion, death oc	ce, and ccurred a	due to the cau It the time, dat	use(s) and m e and place,	anner as sta and due to	ated. the cause(s)
	Vithin Fo the	Me	29b. Signature and title of certifier	1 dans		29c.	License r			29	d. Date signe	ed (Month, L	Dav. Year)
			290. Signature and title or certifier	-	CANE CO	DAD2 - 2-	An of	301	12	1			2005
	10		30. Name and address of person wh	10000									
			URENDRA IC	· SAXENY	,12101	STAND	nef.	7 DR	GEN	MANZ	CWN	mo	20876
	Sta		31. Date filed (Month, Day, Year) 007 19	32 Registr	rar's Signature	Carle 1							
	Registr	al	OOLIJ	LUUJ DE SALAS	J SU 19	A CONTRACTOR OF THE PARTY OF TH							

Wagner	P.O. Box 68760,
l helma	Division of Vital Records,

			Please	Type or Pri	nt in Blacl	k Inc	delible Ink	. Ensure A	II Copie	s Are	e Legible.		
			For State	State of Ma				lealth and M	fental H	ygiệ	● 05	3565	6
_			Registrar 1. Decedent's Name (First, Middle, La	etl		Cer	tificate of	Death	0. Data of E	Reg. N	lo.		
	Physici		Thelma Lucille	Wagner					2. Date of D	D	ay Year	3. Time of D	
	/Medio Examir		4a. Facility Name (If not institution, giv				4b. City, Town, o	or Location of Death	Octob	-	c. County of Death	1:02	Ам
			Manokin Ma	nor			Prince	essAnne			Somer	set	
	Funeral		5. Social Security Number 6. S 218-80-5516	ex 7. Ag □ M 2 X F	e (In yrs. last birt	hday) _ rs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D	irth ay, Yea	r) 9. Birth	place (State or	Foreign
	Director		Usual Residence of Decedent		91	113.			Nov. 2	28,	1913 New	Hampsh	ire
	arylan ahow	1	10a. State 10b. County		10c. City, Town	or Loc	ation					10d. Inside City	
	he Ma	Directo	Maryland Wicomic)	Hebr	on						t <u>y</u> ⊡Yes 2	2 No
	d within 72 hours after death with the Maryland sleen. Jene. Than "natural", or Itams 23a or 28a-f show Tha Medical Examiner must be notified at	Dir	10e. Street and Number 7419 Cherry Walk	Pond			10f. Zip Code			10g. C	itizen of What Co	untry?	
	death ms 23	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13. W	21830	Hispanic Origin? (Spe	ecity Yes or N	0-	USA 14. Race - Amer	ican Indian	
٥	or its		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ X If Yes, Give	No		Yes, specify Cuba ☐ Yes 2/☐ No	dispanic Origin? (Spean, Mexican, Puerto	Rican, etc.)		Black, White	, etc.	
2-003p	hours ural',	d by	3 Widowed 4 Divorced	Year or Dates:				Specify:			Specify: Whi	Lte	
<u>ဂ</u>	in 72 "nat	Completed	15. Decedent's Ec (Specify only highest gra	de completed)		(Give k	ent's Usual Occup ind of work done O NOT use retired	durina most of work	ing	16b.	Kind of Business/I	ndustry	
7	d within giene. ar than "a	mo	Elementary/Secondary (0-12)	College (1-4or 5	+)		nemaker	-7			Own I	Iome	
<u> </u>	e file al Hy othe vent,	Be C	17. Father's Name (First, Middle, Last)					18. Mother's Name	First, Middle	e, Maide		iome	
y N	should be nd Menta i markad imatic ev	10	Lloyd L. Bean					Lura Ma					
Mar	d 2 sh th and 7 Is m traum		19a. Informant's Name/Relationship (Barbara Jean Holm					and Number or Rura					
<u>6</u>	jes 1 and 2 should b t of Health and Ments If Itam 27 Is markao prothar traumatic e		20a. Method of Disposition		20b. Place of	Dispos	ition (Name of	Walk Road,	nebro		Location - City or T		
altimore	permit, Pages Department of I Important: If Its any injury or o once.		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State			atory or other plac ven Cemete	rv OCLOD	er 21,				
<u>a</u>	mit. apartir porta y inju		21. Signature of Funeral Service Lice					ss of Facility Collins	05 Funera	Si]	Lver Spri	ng, Mary	land
	82889).5 AL E.	34/		_50	0 Univer	sity Blvd	, W, S	ilve		, MD 20	901
	normal district		23a. Part1. Enter the disease, or compshock, or heart failure. List only	one cause on each iir	10.				-			Approximate Interval Betwee Onset and De	. Ale
	hysician /Medical	4	Immediate Cause i mail disease or condition resulting in death)	a. CON 62	57/VE	1+	TART	Ettelile	re b	E CO.	magasaz	n DAY	5
	Examiner			ATHM	a consequence o	1): 107 i	oc car	PARLU	11 -2 -2	11/10	4 A CE	WEAR	C
	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence o	f):			1.5	5.71	-	, , ,	3
	be executed sician and burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	C	a consequence of	4).							
_	sician buria			·	z consequence of	1).							
00	The law requires that the death certificate i ate has been signed by the attending physi page 2 should be detached for use as the b	hysician/Medical		d									
YOU	th cert endin r use	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth	of pregnancy	3 □	Ectopic pregnancy			Ĭ	23d. Date of deliv	ery	
5	e dea the at hed fo	sici	in the past 12 months? 1 □ Yes 2 █ No 9 □ Unknown	4☐ Pregnant at 9☐ Unknown			Other (specify)				Month	Day Ye	ar
	that the side by detacle	۵.	Part II. Other significant conditions of	ontributing to death bu	it not resulting in	the unc	fertying cause give	an in Part I	23a Did	tobacco	use contribute to t	he cause of dear	th?
ָהָ מַלְ	ures n sign	d by	RHENMATO	10 ANT	THRITT	S	onlying oddoo give	ari iiri ditt.		Yes 2		pably 4 Doni	_
5	s beel	Completed	DIABETES	meri	1745				24a. Was	an	24b. Were auto	ppsy findings av	ailable
	rsician: The law s certificate has b lirector, page 2 s	mo:				_			auto	psy ormed?	prior to co death?	mpletion of cau	se of
<u> </u>	cian: ertifica actor, I	Bec	25. Was case referred to medical examiner?					26. Place of Death	(Check only	one)			
5	tending Physician: The Beath. tor: After this certificate hat the funeral director, page	2	1 Yes 2 140		nt 2 ER/Outp		3□ DOA Othe	er: 4 Unursing Hon				y)	
5	ding Alter After funer	ertification:	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	Year) 28b. Tii	me of ury	28c. Injury Work	/ at 2 ⟨? Yes 2 □ No	8d. Describe	how inju	iry occurred		
2	Attan r deal actor: by the	ifica	3 Suicide 6 Could not be determined	286. Place of Inju	ry - At home, farr	n, stree			8f. Location (Street ar	nd Number or Rura	il Route Numbe	ď,
בֿ	tal or rs afte al Dir.	Cert	4 Hostilicide	building, etc	. (Specify)				City or To	wn, Stati	e)		
	To the hospital or Attanding Physician: within 24 hours after death. To the Funeral Diractor: After this certifics completely filled in by the funeral director,	edical	Check only 2 Medicer Exem	rsicien: To the best of	f my knowledge, examination and	death o	occurred at the time	ne, date and place, a	nd due to the	cause(s) and manner as s	tated.	
:	thin 2 thin 2 the on the omplet	Med	one) 29b. Signature and title of certifier	and manner sta	ted.		29c. License				ate signed (Month,		
1	F 3 F 8		/_					62916			17/200		
	12	-	30. Name and address of person who d	ompleted cause of de	eath (Item 23a) (T	ype, Pr		06718		10/	14/000	5	
		-5	VETTANA GUTTEME	=2, MD	1415 500	W M	1 11/15/2	N SHITE	B SAZ	156n.	ay mo	21804	
	Stat		31. Date filed (Month, Day, Year) OCT 19 20	39 Registra	r's Signature	Local	K)	•					
	Registra	ar	001 13 20	J. J	15 19								

081-48-3097 Walke Wille

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygin 05 35657 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year WILLIE E. WALKER 0422 M 16 10 05 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PRMC Salisbury Wicomico If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Date of Birth 1**√** M 2□ F (Month, Day, Year) 10/09/37 081-48-3097 68 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Accomack Temperanceville 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26202 Saxis Rd. 23442 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer Farm 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Unknown Gertrude Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Inez Holden, Cousin 26202 Saxis Rd., Temperanceville, VA 23442 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 Demoval from State 4 ☐ Donation 5 ☐ Other (8) Groton Community Cem. 10/23/05 Messon o, VA 21 Signature of Funeral Se 22. Name and Address of Facility Cooper & Humbles Funeral Co., Accomac, VA e, or complications that based the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Part1. Enter the diseas Approximate Interval Betw Onset and Death Immediate Cause (Final MRSA SOOSIS 2_

29d. Date signed (Month, Day, Year)

10/16/05

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

δ

Completed

10a. State

VA

Funeral

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Importent: if Item 27 is marked other than "natural", or Itams 23a or 28a-f show say highry or other traumatic event, the Medical Examinar must be notified at once.

Examiner the attending physician and Physiclan/Medical use as the Completed by To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. Be Certification: To

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Chris Snyder, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OCT 1 9 2045

Division of Vital Records, P.O. Box 68760

resulting in death)	a		
resulting in death)	Due to (or as a consequence of):		
Sequentially list conditions, Tany, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a nonsecuence of):		
that initiated events resulting in death) Last	c. Due to (or as a consequence of): d.		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I. Acric renal Faime	23e. Did tobacco	use contribute to the cause of death?
	Aremia	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5 Residence	6 □Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigati	28a. Cate of Injury (Month, Day Year) 28b. Time of Injury Work? 28c. Injury at Work? 1 \[\] Yes 2 \[\] No	d. Describe how inju	ry occurred
3 Suicide 6 Could not 4 Homicide determine		f. Location (Street ar City or Town, State	nd Number or Rural Route Number, a)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

(PPOZE)

Salisbury MD 21804

State

Registrar

100 E. Carroll St.

32. Registrar's Signature

			1 - For State Registrar	State of Maryland /	Depart Certi	ment of H	lealth and Death		giene Reg. No.	105	35658
H	Physic /Medi		1. Decedent's Name (First, Middle, Last)	WARBA	1550	-		2. Date of De Month	Day	Year	3. Time of Death
	Examin		4a. Facility Name (If not institution, give s COASTAL HOSP! 5. Social Security Number 6. Sex	treet and number) CEAT 11-1EU 7. Age (In yrs. last I	4/(E 4 birthday) 1		Location of Deat	8. Date of Bir	th W		100
L	Director		009-18-1482 Usual Residence of Decedent	M 2√F 77	Yrs.	ionins Days	Hours Min.	(Month, Da 11-25-			Jersey
	Marylan -f show ii-d at	tor	10a. State 10b. County MD Somerset	10c. City, To		ion					10d. Inside City Limits 1 Yes 2 □ No
	vith the	Director	MD Somerset 10e. Street and Number	West		10f. Zip Code			10g. Citize	on of What Cou	
	na 23e	Funeral	7526 Old Westove	2. Was Decedent Ever in U.S.	13. Was		1871	Specify Yes or No	- 14	USA I. Race - Amer	ican Indian
5-0036	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Itema 23e or 28e-f show event, I'm Madical Examinar must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1		Yes 2/X No	Specify:	Specify Yes or No to Rican, etc.)		Black, White pecify:	
1215-(vithin 72 h ne. han "natu u Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give kind	's Usual Occupa d of work done o NOT use retired,	luring most of wo.	rking	16b. Kind	of Business/li	
N	Tygi Thar	Be Co	12 17. Father's Name (First, Middle, Last)	5+	Prof	essor	18. Mother's Nar	me (First, Middle	Commi	unity C	ollege
Maryland		To B	Harry Bowles				Eliabeth	Caroli	ne Phi	raner	
Mar			19a. Informant's Name/Relationship (Type James Richard Wart					ural Route Numbe			
Baltimore,	iges 1 and 2 it of Health If itam 27 I		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	20b. Place	of Disposition	on (Name of ony or other place)	Date		MD 2187 ition - City or T	
altir	permit. Pages i Department of H Important: If its any injury or ot		`4 □Donation 5 □ Other (Specify)	Salis	sbury	Cremato	ry 10/1. s of Facility eral Hom	5/2005	Sali	sbury,	Maryland
m	90 1 8		anas Jun	XX 1 M00295	116	73 Some	set AVe	Princ	ess A	nne. M	D 21853
ı	hysician /Medical	4	28a. Part1. Enter the divease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)	ations that caused the death. Do	Carc	ne mode of dying	such as cardiac Lank	or respiratory as	Prim	ny	Approximate Interval Between Onset and Death
	Examiner		Sequentially list conditions, b.							5	
	xecuted and al-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence							
09/89	licate be executed physician and s the burial-transit	edical E	d.								
ROX	ath certif attending for use a	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat 4 Pregnant at time of death 9 Unknown		opic pregnancy ner (specify)		-	230	d. Date of delive Month	ery Day Year
- 3	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions cont	ributing to death but not resulting	in the under	lying cause give	n in Part I.	23e. Did to			ne cause of death?
r ,	ine la ate has page 2	Completed						24a. Was autop perfor	sy	24b. Were auto prior to co death? 1 Yes	psy findings available mpletion of cause of
on or vital	id id	tion: To Be	25. Was case referred to medical examiner? 1 Yes No 27. Manner of Death Matural 5 Pending investigation	28a. Date of Injury 28b.	Outpatient 3 Time of Injury	DOA Other	4 □ Nursing H	th (Check only of one 5 Reside 28d. Describe h	ence 6	Other (Specific	y)
DIVISION	To the mospital or Attending Privation 24 hours after death. To the Funaral Director: After the completely filled in by the funera	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fi building, etc. (Specify)			2 2 1.10	28f. Location (S City or Tow	treet and N n, State)	lumber or Rura	il Route Number,
	a noapi 24 hour 16 Funari 16tely fills	edical (29a. Certifier 1 Cartifying Physic (Check only one)	cian: To the best of my knowledg ir: On the basis of examination are and manner stated.	ge, death occ nd/or investi	surred at the time gation, in my opi	e, date and place, nion, death occur	, and due to the or rred at the time, o	ause(s) and late and pla	d manner as si ace, and due to	tated. the cause(s)
	vithir To th	_	29b. Signature and title of certifier	20		29c. License	number	2	9d. Date s	igned (Month,	Day, Year)
		r	30. Name and address of person who com	Dieted cause of death (Item 222)	(Type Bri-	102	6278	5	10	-/2	-05
			DAVIDE CONALL,	pleted cause of death (Item 23a) ### COASTAL 32. Registrar's gnature 9 200	HOS	PICE	PO BO	x 1733	Sal	156m	MD 21802
	Sta Registra		31. Date filed (Month, Day, Year)	32. Registrar's gnature	· K	Scart.	,	,		0	

		500	1 - For State Registrar		f Maryla		artmen rtificat					g. No.)5 3	35659
	Physici /Medi		1. Decedent's Name (First, Middle, La Katina	Monique		Yates					2. Date of Deati Month October	Day	Year 005	3. Time of Death 10:20 a .mm
>	Examir	ner	4a. Facility Name (If not institution, gi				4b. City,		Location o				nty of Death	
			48060 Leeward 5. Social Security Number 6.		-	103 s. last birthday)	If Linder	Lex	kingte If Under 2		rk 8. Date of Birth	St	. Mary	
-	Funeral Director		579-94-4349	1 □ M 2 🖪 F	34		Months	Days	Hours	Min.	s. Date of Birth (Month, Day, Sept. 30		Cour	lace (State or Foreign ltry) Land
	pue *		Usual Residence of Decedent 10a, State 10b, County		10c. C	ity, Town or Lo	cation						1	0d. Inside City Limits
	darylan f show	ō	,					T)1-					1 ☐ Yes 2 ■ No
	the 128a-	Funeral Director	Maryland St. M. 10e. Street and Number	ary's			xingt 10f. Zip		ark		10	a Citizen o	of What Coun	stry?
	3a or	0	48060 Leeward C	ircle. A	nt #1	03			20653					•
	deat	ner	11. Marital Status	12. Was Dece	dent Ever in		Was Deced			gin? (Spec	rify Yes or No- ican, etc.)	14. R	ted St	an fndian,
20	72 hours after death with the Maryland natural; or Items 23s or 28s-f show diesi Examinat he rotified at		1 ■ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tes If Yes, Giv Year or Da	2 👹 No e		rres, spec 1 ☐ Yes		Specify:	, Риепо н	ican, etc.)		lack, White, c <i>ify:</i> Blac	
21215-0036	2 hou	Completed by	15. Decedent's E	ducation		16a. Deced	lent's Usua	al Occupa	ition		1	6b. Kind of	Business/Inc	dustry
27	within 7 ene. than "n	npie	(Specify only highest gr Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT us	rk done d se retired)	uring most	ot working	9			
	filed within Hygiene. other than ent, tre M	S	12			Nu	rsing						althca	re
	be fil od oth	Be	17. Father's Name (First, Middle, Last)							(First, Middle, M			
<u> </u>	should be nd Mental marked o	스	Unknown	T 0 (-1)		4-1 14 111					oraine			
Maryland	d 2 sho th and 17 is ma trauma		19a. Informant's Name/Relationship		.						Route Number,			
Baltimore,	Pages 1 and 2 should be filed within 72 hours after death with the Maryian nent of Health and Manial Hyglene. Int: If item 27 is marked other than "natural; or items 23e or 28e-f show int: If item 27 is marked other than "natural; or items 12e collined at yry or other traumatic event, it a Madical Examinational Secretified at		Agnes F. Somervi 20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from S	20b. State	Place of Dispo cemetery, cren	sition (Nan natory or o	ne of ther place	9)	HO I I	ywood, 1		and 20 n - City or To	
	= E E E		4 ☐ Donation 5 ☐ Other (Speci 21. Signature of Funeral Service Lice	- /4	St	. John'	s Cen	eter	y 1	10-26	-2005 H	o11ywo	ood, M	aryland
Ba	Dep Impo	1		74/2	W01	206 20	. Name an	d Addres	s of Facility	Brin.	sfield :	Funera	al Hom	e, P.A.
			Kyle S. Simons 23a. Part1. Enter the disease, or comshock, or heart failure. List only		MO1		955 E	lotty e of dvind	WOOd	Road cardiac or	• Leona:	rdtowr	n, MD	20650-0279 Approximate
	Physician		shock, or heart failure. List only fmmediate Cause (Final disease or condition resulting in death)	a. Rho	blor	nyosa	or gor	na	of	Left	ethm	10,000	nus	Interval Between Onset and Death
	/Medical Examiner		resulting in dealin)	Due to (d	or as a conse	quence of):	inch	m	etas	tas.	s to	orai	0	7 manh
i lii		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (c	or as a conse	quence of):								
	and and I-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (c	or as a conse	quence of):								
6876 0,	fficate be executed physician and is the burial-transit	edicai E		d	71 d3 d c01136	quence on.								
200	ntifica ng ph		IF FEMALE:											
X D	leath certifi attending I I for use as	lan/I	23b. Was decedent pregnant in the past 12 months?		rth 2□Fet	af death 3	Ectopic pre	egnancy					ate of deliver	,
5.	The law requires that the death cert, the has been signed by the attending bage 2 should be detached for use a	Physician/M	1 Yes 2 No 9 Unknown	4□Pregna 9□Unkno	int at time of wn	death 5□	Other (spe					, N	fonth	Day Year
J.	res that igned b be deta	by Pt	Part If. Other significant conditions	contributing to de	ath but hot re				n in Part I.		23e. Did toba	icco use cor	ntribute to the	e cause of death?
or vital Records,	en sig	ed b	Sevore naus	ca vo	miting	F. An	emi	2,			1 🗆 Yes	2. No	3 ☐ Proba	ably 4 Unknown
ည	e law requ has been je 2 shouk	Completed	low back pa	in,							24a. Was an	24b	. Were autop	sy findings available
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2	iicien: Th certificate rector, pag	Be (25. Was case referred to medical examiner?						26. Pface	of Death	Check only one			
5	hysic this co	2	1 ☐ Yes 2 No] ER/Outpatien			4 U Nurs	sing Home	5 🔀 Residen	ce 6 □Ot	ther (Specify))
ב	Jing Ph	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of (Month)	f Injury , <i>Day Year)</i>	28b. Time of Injury		Bc. Injury Work?		1	d. Describe how	infury occu	irred	
DIVISION	death. ctor: A y the fu	cat	2 Accident investigation 3 Suicide 6 Could not b		-/1-: 41.1		М		es 2□N					
2	s after el Direct	Certification:	4 Homicide determined	28e. Place	of In _f ury - At h g, etc. <i>(Speci</i>	nome, farm, stre ify)	et, factory	, office		28	f. Location (Stre City or Town,	et and Num State)	ber or Rural	Route Number,
	To the hospitel or Attending Physicien: within 24 hours after death. To the Funarel Director: After this certifica completely filled in by the funeral director.	edical (29a. Certifier Certifying Pt (Check Only one)	ysician: To the l niner. On the ba and mann	sis of examina	owledge, death ation and/or inv	occurred a estigation,	at the time in my opi	e, date and nion, death	place, and	d due to the cau at the time, dat	se(s) and m e and place	nanner as sta , and due to	ited. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			22.0	29c.	License	number	0	290	d. Date sign	ed (Month, D	Day, Year)
	_	1				$m_{\mathcal{D}}$	D	51	73	8		0.5	14,2	20631
			30. Name and address of person who KAR T. AUNG	, 744	35 M	iervei	rint)	DEAL	N (.	2D. 1	HOLLYI	NOOD	mD	20631
* * *	Sta		31. Date filed (Month, Day, Year) OCT 2 5	2005 32. B	gistrar's Sign	ature	hand.	,						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35660 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 27, 2005 11:40 A.M. October Sister Amelia Zurgable /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Frederick St. Vincent Care Center Emmitsburg If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 ☐ M 2 🖾 F Months Yrs. 96 Sept. 18, 1909 Maryland Director 215-50-1107 Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Meryland Depertment of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumetic event, if a Medical Examinar must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☑ Yes 2 ☐ No Director Frederick Emmitsburg 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 335 South Seton Avenue Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 → Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 Widowed 4 Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Religious Community Elementery/Secondary (0-12) College (1-4or 5+) Daughters of Charity Dietitian College 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas George Zurgable Virginia Gertrude Lingg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 333 S. Seton Avenue, Emmitsburg, MD Sister Camilla Harant 21727 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition r place) 1 Burial 2 □ Cremetion 3 □ Removal from State NEW ST. JOSEPH'S P.H.10/31/05 EMMITSBURG, MD 21727 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature / Funeral Service Licensee 22. Nama and Address of Facility SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727 onn of ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, rheart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or es a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed ettending physician end for use es the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2♥ No 3 Probably 4 Unknown ٥ 24b. Were eutopsy findings available prior to completion of cause of deeth? plnods Completed 24a. Was an autopsy performed? After this certificete has funeral director, page 2: 2 🕅 No 1 Tyes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: ours efter death.

•cal Director: After this certifical filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4₺ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ 1 ☐ Yes 2X No 27 Menner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 K Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funetal C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 2 Medicai 29d. Date signed (Month. Day, Year) 29b. Signature end title of certifier 29c. License number OCTOBER 28, 2005 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

State Registrar ALAN CARROLL, M.D.,

31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

th, Day, Year)

32. Registrar's Signature

310 S. SETON AVE.

ORIGINAL

EMMITSBURG, MD. 21727

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Mary		artment of F			2005	35662
			Decedent's Name (First, Middle, Last	st)				2. Date of Death		3. Time of Death
	Physicia /Medic		George	С.		A1	ston	Month October	Day Year 29, 2005	7:34 A ^M
	Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	or Location of Death		4c. County of Deatl	
			Washington Adven			Takoma			Montgome	
	Funeral Director		5. Social Security Number 6. S	ex 7. Age (In ☑M 2□F	yrs. last birthday) O 1 Yrs.	Months Days	Hours Min.	(Month, Day, 1	Year) Co	nplace (State or Foreign
			229-01-7457 Usual Residence of Decedent		91 Yrs.			June 5,	1914 Nort	h Carolina
	ylanc		10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits
	Ba-f s	ctor	Maryland Prince G	eorge's H	yattsvill	Le				1 ☐ Yes 2 💢 No
	or 28	Directo	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Co	untry?
	s 23s		1600 Ridge Road			20781			U.S.A.	
	item item	Funeral	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ANo		Was Decedent of H f Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White	
39	urs af	ρ	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1□Yes 2፟ÄNo	Specify:		Specify: Bla	ck
Ģ	72 ho	Completed	15. Decedent's Ec (Specify only highest gra		16a. Deced	dent's Usual Occup	pation during most of wor	ting 16	6b. Kind of Business/I	
2	ithin ne.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retire	d)			
2	led w lygier her th		17 Forbada Nama (First Adiabata 1 and		Be.	llman	40.14.1.11		partment B	uilding
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other then "natural," or items 23s or 28s-f show other treumatic event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last) Charlie Alston					ne (First, Middle, Ma	aiden Sumame)	
Ž	2 should and Men is marke eumatic	은	19a. Informant's Name/Relationship	Type, Print)	19b. Mailir	ng Address (Street		Burgess	City or Town, State, Z	in Code)
S	nd 2 suith ar		James Alston (So						lboro, MD	
ē,	s 1 ar		20a. Method of Disposition	2	Ob. Place of Dispo			The state of the s	Oc. Location - City or	
Ë	Page nent c nt: If		1X Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify	Removal from State			hurch 11,	/5/05	Warrenton	, NC
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 is any injury or other tree		21. Signature Funeral Service Lice	500	22	. Name and Addre	ss of Facility	arvice		27589
	897.		Cennis).	Monum		1120 Mai	CIH DUCIE	er kring b.	lvd., Warr	enton, NC
П			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	olications that caused the one cause on each line.	death. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arres	et,	Approximate Interval Between Onset and Death
	Physician	ŭ i	Immediate Cause (Final disease or condition resulting in death)	a. (brown	ary /40	Ten	Disea.	ce		Onset and Death
	/Medical Examiner		Toodking in dodain,	Due to (or as a co	nsequence of):	/				
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co	nsequence of):					
V	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	6						
0	en an		resulting in death) Last	Due to (or as a co	nsequence of):					
8760	cate be executed physicien and the burial-transit	dical	•	d						
9	eath certific attending p	a) i	IF FEMALE:	22a If ups outcome of pe						
Вох	attend for us	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pr 1 Live birth 2 4 Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)	1		23d. Date of deliments	very Day Year
o.	y the	Physician/Me	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	ordeath 5	Other (specify)				
٥.	The law requires that the death certificate has been signed by the attending to age 2 should be detached for use as	by Pt	Part II. Other significant conditions of	ontributing to death but no	t resulting in the ur	nderlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ğ	w require been sig should b							1 ☐ Yes	2 XNo 3 ☐ Pro	bably 4 Unknown
Records,	law re as bee	Completed						24a. Was an	24b. Were aut	opsy findings available ompletion of cause of
		Com						autopsy performe	ed? death?	2□ No
Vita	Physicien: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one)		
ot \	shys al di	ို	1 ☐ Yes 2X No		2 ER/Outpatien		4 Nursing H		ce 6 □Other (Spec	ify)
u C	ding After fune	Certification:	27. Manner of Death 1X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Time of Injury	28c. Injur Wor M 1	yat k? Yes 2 □ No	28d. Describe how	injury occurred	
Division	l or Attending after death. Director: After in by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be determined		At home, farm, stre		195 2 LINO	28f. Location (Stre	et and Number or Ru	ral Route Number
2	To the Hospitel or Ati within 24 hours after of To the Funerel Direct completely filled in by	erti	4 Homicide	building, etc. (S	pecify)	301, 1401017, 011100		City or Town,		ar risulo realizor,
	pspite hours unere		29a. Certifier 1 X certifying Ph	ysician: To the best of my	knowledge, death	occurred at the tin	ne, date and place,	and due to the cau	se(s) and manner as	stated.
	he He in 24 he Fu	edical	one)	niner: On the basis of exa and marmer stated.	mination and/or inv	estigation, in my o	pinion, death occur	red at the time, date	e and place, and due	to the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier			29c. Licens		290	d. Date signed (Month	, Day, Year)
	\wedge		1466	con			203		October 3	1, 2005
	7		30. Name and address of person who				O Toles-	no Dowle 1	MD 20012	
	Sta	to	Stephen Smith, M 31. Date filed (Month, Day, Year)	32. Registrar's S		ITTUIT AV	c., lakon	na Park, N	MD 20012	
	Registr		NOV 0. 4 20		H. Aga	de				
			1404 0 3 40		- FE 1994					

			1 - For State	State o	f Marylar		artment of tificate o			ental Hy	•	2005	3:	5660
		ш	Registrar 1. Decedent's Name (First, Middle, La	st)		007	incate c	Dean		2. Date of De	Reg. No		3. Tin	JOOJ le of Death
	Physici		Val	lentino	Caoili	Alinio				Month Octob	or 3		8:0	6 A M
	/Medio Examin		4a. Facility Name (If not institution, giv			7111010	4b. City, Town	n, or Location	n of Death	OCCOD		County of Dea	1000	U A
			Suburba	an Hospi	ta1			Beth	esda			Mon	tgomen	v
	Funeral		5. Social Security Number 6. S		7. Age (In yrs.		If Under 1 Ye Months Da			8. Date of Bit (Month, Da	th ay, Year			ate or Foreign
	Director		399-40-6407 Usual Residence of Decedent	XIM ZUF	72	Yrs.			I	ebruary		1933 P	hilip	pines
	land		10a. State 10b. County		10c. Ci	ity, Town or Lo	cation						10d. Insid	e City Limits
	Mary 	Ď	Maryland Mont	gomery				Bethe	ada				10	Yes 2 No
	728a	Director	10e. Street and Number	gomer y			10f. Zip Cod		sua		10g. Ci	tizen of What C	ountry?	
	h with		8543 West	· Howell	Road			208	17			Unite	d Stat	. 60
	deat	Funeral	11. Marital Status	12. Was Dece Armed Fo	dent Ever in U		Was Decedent of Yes, specify C	of Hispanic C	Origin? (Spec	city Yes or No)-	14. Race - Am Black, Whi	erican India	
36	or it	J.	1 ☐ Never Married 2 ☑ Marned	1 □Yes If Yes, Giv	2 X No	1	l□Yes 21X01			110011, 010.7		Specify:	ie, eic.	
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ď	be filed tal Hygi d other event,	Be C	17. Father's Name (First, Middle, Last							(First, Middle	, Maidei		Ommer	
/lar	uld by Menta rrked rife e	ToE	Ar	duro Al	ipio					Eusta	inui;	a Caoil	i	
Maryland	2 should be and Mental is marked is marked in	·	19a. Informant's Name/Relationship (Type, Print)	5	19b. Mailin	g Address (Stre	et and Numi	ber or Rural			or Town, State,		
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altimore,	Pages 1 nent of H int: if ite		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐]Removal from		cemetery, cren	sition (Name of natory or other p ate	olace)	Noven	nte nhor	20c. L	ocation - City or	Town, Stat	Ð
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Bal	permit. Departi Import any inj once.		21. Signature of Juneral Service Lice)	/	Be	thesda- thesda- thesda	dress of Faci -Chevy	Chase	rt A.	Pum 75	phrey F	uneral	Home/
			23a. Part1. Enter the disease, or seem	perconsthat c	MOO3	<u> </u>	: LileSua	Mary.	rand 2	.0014-	COUL		Approx	
			shock, or heart failure. List only Immediate Cause (Final	one cause on e	ach line.	1	or the mede of t	1.					Interval	Between nd Death
	Physician /Medical		disease or condition resulting in death)		or as a consec	art	ery	a19	e ase	2			yea	ths
	Examiner		Carrier or transport to Market		0, 45 4 00,500	4401100 01).							ı	
	7 - 2	ner	Sequentially life conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quence of):								
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50,	cate be executed obysicien and the burial-transit		1830kiing in deality Last	Due to (or as a consec	quence of):								
8760,		dical		_ d										
9 X	death certifica e attending pl ed for use as t	/Me	IF FEMALE:	23c. If yes, out	come of prean	ancv						024 Data -64-	C	
Вох	leath atter i for u	clar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live b	irth 2 ☐ Feta ant at time of c	al death 3□	Ectopic pregna Other (specify)					23d. Date of de Month	Day	Year
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ر. م	The law requires that the ste has been signed by the bage 2 should be detache	by Physician/Me	Part II. Other significant conditions of	contributing to de	ath but not res	sulting in the ur	derlying cause	given in Part	tH.	23e. Did t	obacco	use contribute to	the cause	of death?
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<u> </u>		ЮП								perfo	rmed? 2 No	death?	1 /	or cause or
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?						ce of Death	(Check only o				
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L C	fing f	lo	27. Manner of Death 1 Natural 5 □ Pending		h, Day Year)	28b. Time of Injury	V	york?		3d. Describe	how inju	ry occurred		
Division of	Attending ir death. ector: After by the fune	licat	2 Accident investigation 3 Suicide 6 Could not b	e Georgian	of Injury - At h	ome farm str	eet, factory, office	Yes 2		of Location (Street at	nd Number or R	ura l Route I	lumber
Š	after after Dire	Certification:	4 Homicide determined	buildir	ng, etc. (Speci	fy)	ou, ractory, one			City or To	wn, State	a)	ura, riodie r	vaniber,
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral		29a. Certifier 1 ☐ Certifying Ph	ysician: To the	best of my kno	owledge, death	occurred at the	time, date a	and place, ar	nd due to the	cause(s) and manner a	s stated.	
	he Ho in 24 he Fu	edical	(Check only 2 Medical Exar	niner: On the ba and mann	isis of examina	ation and/or inv	estigation, in m	y opinion, de	eath occurred	d at the time,	date an	d place, and due	to the cau	se(s)
	To t Com	Σ	29b. Signature and title of certifier	1	4	M.	29c. Lice	ense number			29d. Da	te signed (Mont	h, Day, Yea	r)
)			Pallicia	10m	2/20	ing,	Mac V	019/1	6		UCT	, 30,	100E)
	10		30 Name and address of person who	completed caus	e of death (Iter	m 23a/(Type,	Print)	D. La	0 11	20 D	1		nn/	10000
	Sta	to	31. Date filed (Month, Day, Year)	N /V9	gistrar's Signa	ature &	VIIIE	rike,	6-10	y KC	OCK	VIIIe, 1	111/2	0852
	Registr	_	NOV 0 4 2005	Male	5 15	BOOME						•		

Nannie Bowman 05-7306 AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygier O O F

			1 - For State Registrar	State of M	Ce.	rtificate of Dea	n and Mental I	Tygien Reg. N	and the same office.	35664
200	Physici /Medic	al	Decedent's Name (First, Middle, L Nannie Aa. Facility Name (If not institution, g.)	2	E	Owman - 4b. City, Town, or Locati	2. Date of Month Octo	ber 2	ay Year 9, 2005 c. County of Deat	3. Time of Death 8:07 P
1	Examir	lei	Good Samaritan H		,	Baltimore	ion of boat.	~	NA	11
Y.	Funeral Director		213-70-2322	Sex 1 □ M 2 🛱 F	ge (In yrs. iast birthday) Yrs.	If Under 1 Year If Un Months Days Hou		Birth Day, Year		hplace (State or Foreign ountry)
	rland ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	a-fsh	ctor	M. N	A	Ba	ltimore				Y☐Yes 2☐No
	or 28	Dire	10e. Street and Number			10f. Zip Code		10g. C	itizen of What Co	untry?
	eath v	era	115 E. Melrose	Avenue	Ever in ITS 12	21212	Oddien (Const.)		USA	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Hem 27 is marked other than "natural", or Iteme 23s or 28s-1 show any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 → Married 3 □ Widowed 4 □ Divorced	Armed Forces' 1 Yes 2 Il Yes, Give Year or Dates:	?	Was Decedent of Hispanic If Yes, specify Cuban, Mex 1 ☐ Yes 2 XNo Spec		No-	14. Race - Ame Black, White Specify:	
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ary	shoul and Me mark	J.	19a. Informant's Name/Relationship	(Type, Print)		ng Address (Street and Nu	mber or Rural Route Nu	mber, City		
	and 2 salth a n 27 ls		Barbara Blount	Sister	571	l Denwood Av				206
altimore,	ges 1 t of He if Iten or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	Removal from State	20b. Place of Dispo cemetery, crer	sition (Name of natory or other place)	Date	20c. L	ocation - City or	Fown, State
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	s that gned b	y P	Part II. Other significant conditions	contributing to death b	out not resulting in the ur	nderlying cause given in Pa	art I. 23e. D	id tobacco	use contribute to	the cause of death?
ä	w require been sig should b	ted	CEREBRAL	ATHEROS	CUEROSIS		1	☐ Yes 2	No 3□ Pro	obably 4 Unknown
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	To the Hospital within 24 hours and to the Funeral completely filled	edical	(Check only XX Medical Exa	miner: On the basis o and manner st	i examination and/or inv	restigation, in my opinion, o	death occurred at the tim	ne, date an	d place, and due	to the cause(s)
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	3		30. Name and address of person who	completed cause of o		•	oot Dolle	0.00	M 1	01007
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Registrar

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The state of the s	920	al', or Iter	by	1 Never Married 2 Married 1 Yes 2 No				Rican, etc.)	Black, V	Vhite, etc.
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Section Sect	7	ted nsit	nlner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	quence of):					
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State Stat	/Ita	cian: ertifica ector, I	ø.	examiner?						65 2 140
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State 31. Date filed (Month, Day, Year) 3# Registrar's Signature		To the trought comp		29b. Signature and title of certifier De_{f}	enty					
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				31. Date filed (Month, Day, Year) 32. Registrar's Signa	ature	w	Y	, C A	0103	

Christian Berger 05-07284 NJ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

M	204		_ For	State of Maryland /	Department	of Health and	Mental Hyd	iene	-
			1 - State Registrar	•	Certificate			leg. Ro. 1 1 5	35666
	Dhysisi	V j	1. Decedent's Name (First, Middle, Las	0 11.	Ω		2. Date of Dea Month	th	3. Time of Death
	Physici /Medic		Christian	Mudolph	Derger		October	28 200	
	Examir	er	4a. Facility Name (If not institution, give		4b. dity, To	own, or Location of Dea	th	4c. County of D	eath
200		ji.	Upper Chesapeake 5. Social Security Number 6. Se			Air Year If Under 24 Hrs	8. Date of Birth	Harford	
	Funeral Director			M 2 F		Days Hours Min.		Year)	Birthplace (State or Foreign Country)
			Usual Residence of Decedent	01			12 27	-90 0	ermany
	arylar arbow	70	10a. State 10b. County		own or Location				10d. Inside City Limits
	with the Marylan or 28e-fahow	Director	MD Hart	ord	Forest				1 ☐ Yes 2 No
	death with the Maryland me 23a or 28e-f ahow f mast be neithed at		1139 Walter	= MII Ral	10f. Zip C	21050	1	Og. Citizen of What	Country? Λ
	me 23e	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decede		Specify Yes or No-	14. Race - A	merican Indian,
9	or the	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give		nt of Hispanic Origin? (S y Cuban, Mexican, Puer	to Rican, etc.)	Black, W	
003	hours after tural, or tte	d by	3 Widowed 4 Divorced	Year or Dates:	1 ☐ Yes 2	i No Specify:		Specify: U	Thite.
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lar	should be ad Menta marked matic av	10 B	Joseph Ber	aer		Gertr	ud F	altus	
Maryland	d 2 should th and Men 7 is marks treumatic		19a. Informant' Name/Relationship (7	yp , Print) 19	9b. Mailing Address (Street and Number or Ru	ural Route Number	City or Town, State	a, Zip Code)
	s 1 and 3 Health Item 27 other tr		Armin Berger	1	139 Walt	ers Mill t	d Fores	THIL ME	21050
076	9 ± ± 5		20a. Method of Disposition (1 Disposition 3 Disposition 4	Removal from State	of Disposition (Name tery, crematory or other	er place)		20c. Location - City	
Baltimore,	permit. Par Departmen Importent: eny Injury		4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service Aicens		ry's Chure	h(om. 111-	4-05	Pylesville	MO
Ba	permit. Departm Importe any Inju		21. Signature of Funeral Service dicent	Sayles IV.	22. Name and	Address of Facility FC	REST HII	LL, MD Z	1050.
	1.00		23a. Part1. Enter the disease, or composhock, or heart failure. List only	lications that caused the death. D	o not enter the mode	of dying, such as cardia	COT respiratory arre	HIK, OK	EW PORT DR. Approximate
1	Physician		Immediate Cause (Final	he cause on each the.		udiovas			Interval Between Onset and Death
A	/Medical		disease or condition resulting in death)	a. Due to (or as a consequence		way o you	and o	11 Jesse	
ÿ.	Examiner		Sequentially list conditions	b					
14	Sit 9d	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	e of):				
6	and and II-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as a consequenc	e of):				
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687	ificate g phy: as the			d					
Вох	death certifica e attending ph of for use as t	Physician/Me	230. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea	th 3 □Ectopic preg			23d. Date of c	lelivery
	0 0 0	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of death	5 ☐ Other (spec			Month	Day Year
P.O.	a of	Phy	9 Unknown						
ds,	S C 0		Part II. Other significant conditions co	ntributing to death but not resulting	in the underlying cau	se given in Part I.			to the cause of death?
Š		etec	ug:npriance						Probably 4 Chknown
Rec	The law ate has b page 2 st	Completed by					24a. Was ar autops perform	n 24b. Were y prior t ned? death	autopsy findings available ocompletion of cause of
a	ificate or, pa	မ ပိ	25. Was case referred to medical			00 Pt(D-	1 De Yes 2	.□ No 1 🛛 Y	
>	Physicien: The law this certificate has E ral director, page 2 s	To B	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ÆR/C	Outpatient 3 DOA	04	th (Check only one	<i>e)</i> nce 6 ∐Other <i>(S)</i>	nout d
ام د	ng Phys ter this neral di	L:u	27. Manner of Death 1 XNatural 5 □ Pending	45		Injury at Work?	28d. Describe ho		<i>веспу)</i>
Sior	Attending ir death. actor: After by the fune	atic	2 Accident investigation	(main, bay roar)	М	1 ☐ Yes 2 ☐ No			
Division of Vital Records,	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, o	ffice	28f. Location (Str City or Town	reet and Number or , State)	Pural Route Number,
	urs a		20. O. 47'.						
	To the Mospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best of my knowled: ner: On the basis of examination a and manner stated.	ge, death occurred at and/or investigation, in	the time, date and place my opinion, death occu	, and due to the ca rred at the time, da	iuse(s) and manner ite and place, and d	as stated. ue to the cause(s)
	ro the somple	Me	29b. Signature and title of certifier	and marrier states.		icense number	29	d. Date signed (Mo	nth, Day, Year)
	/		Mat. a	mich - topo e	1	OCME		ctober, 2	
	16		30. Name and address of person who co	ompleted cause of death (Item 23a) (Type, Print) 111	Penn Stre			yland 21201
	1		TATRICIA Ara	DIGA-POLLAK	an				J
	Sta Registra	_	31. Date filed (Month, Day, Year)	32/Registrar's Signature	books				-

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. U . Decedent's Name (First, Middle, Last) 2. Date of Death 31, Physician OCTAVIA **BROADWAY** OCTOBER 2005 11:40AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FUTURECARE-OLD COURT RANDALLSTOWN BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 11-20-1921 Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 KF Hours Min. Director 83 Yrs. 220-82-7640 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or Itame 23a or 28a-f show traumatic event, the Medical Examinat must be muified at 10d. Inside City Limits 1 ☐ Yes 2 ☐ No MD BALTIMORE WOODLAWN Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3147 JEFFLAND ROAD USA 21244 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify þ 3 XWidowed 4 ☐ Divorced Specify BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuaf Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 HOUSEWIFE HOME 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental H lant: If item 27 is marked off 18. Mother's Name (First, Middle, Maiden Surname) 2 PLEZ LITTLE MARY CROWDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY EASTMAN/ DAUGHTER 3147 JEFFLAND ROAD BALTIMORE, MARYLAND 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5 permit. Page Department of Important: If any injury or once. GARRISON FOREST V.A. MILLS. MD F.H., INC. 11-7-2005 OWINGS 22. Name and Address of Facility JAMES A. MORTON 21. Signa use of Funeral Service Licensee 1701-31 LAURENS ST. 21217 BALTIMORE, MD 9. mes MILLEN 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sebsis **Physician** /Medical Due to (or as a consequence of): Deculitus wicer stage TV Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit be executed and Due to (or as a consequence of): Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy be detached for in the past 12 months? Day Year 4☐Pregnant at time of death Yes 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 TYes 2 No 3 Probably 4. Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Compl has autopsy performed? res 2 No Division of Vital 1 ☐ Yes 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 1 ☐ Yes 2 No ٩ 1 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D25 01 2005 awa 30. Name and address of person who completed cause of death (frem 23a) (Type, Print) MD21117 Suite 10,1 rossroadsbr 20 Kawa lahoora Owings 31. Date filed (Month, Day, Year) egistrar's Signature State NOV 0 4 2005 Registrar

		1	State of Maryland / Departr 1 - State Registrar Certifit	ment of Health and Mericate of Death	ntal Hygien,	71115 35668
	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last) fatricia Denise Baxter		Date of Death Month Da	1105 11:35 PM
}	Examin	er	PRINCE GEORGE COMMUNITY HOSPITAL		Date of Birth	PRINCE GEORGES 9. Birthplace (State or Foreign
	Funeral Director		174-44-5176 1 M 27F 53 Yrs. Mc	onths Days Hours Min.	(Month, Day, Year APRII 15	Country) 1952 PENNSYLVANIA
	Maryland	tor	10a. State 10b. County 10c. City, Town or Location MARYLAND PRINCE GEORGES LARGO	n		10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	with the 3e or 28e	Direc		0f. Zip Code 20743	10g. C	itizen of What Country?
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 le marked other than "nature!; or Items 23e or 28e-1 show other traumetic event, If a Madical Examinar anal burnellised at	by Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	Decedent of Hispanic Origin? (Specifics, specify Cuban, Mexican, Puerto Rice Yes 2XIMo Specify:	y Yes or No- ean, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK
215-0036	rithin 72 hounde.	Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	's Usual Occupation If of work done during most of working NOT use retired)		Kind of Business/Industry
and 21	should be filed withir nd Mental Hygiene. marked other than imetic event, ILE M.	Be	17. Father's Name (First, Middle, Last)	MANAGER 18. Mother's Name (F	First, Middle, Maide	BLIC STORAGE CO
Maryland	2 should and Men Is marks raumetic	2		CORA DO	Route Number, City	
	Pages 1 and 3 nent of Health int: If item 27 iry or other tr	1	Cora P. Young/Mother 1504 C1 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 20b. Place of Disposition cemetery, cremator	earview St., Phil on (Name of Date ony or other place)		Pa 19141 Location - City or Town, State
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		21. Signature 1 uper Service Menniee 22. Na WII	CEMETERY 11-11- ame and Address of Facility LLIAM C BROWN COMM		ILADELPHIA, PA. NERAL HOME P.A.
	20260		23a. Pater. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	06 W NORTH AVENUE ne mode of dying, such as cardiac or r	espiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a	COLPGIAL 1		
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):	LIDIZY FAIL	426-	
>,0928	ate be executed hysician and the burial-transit	licai Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): d.			
O. Box 6	death certific e attending p d for use as	Physician/Medi		topic pregnancy her (specify)		23d. Date of delivery Month Day Year
ο.	requires that the d teen signed by the hould be detached	by	Part II. Other significant conditions contributing to death but not resulting in the under	rtying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death? 2 🗌 No 3 🗆 Probably 4 💆 Unknown
Vital Records,	The taw ate has b page 2 s	Completed			24a. Was an autopsy performed? 1 Yes 2 2 N	
	Physician: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	26. Place of Death (6		6 ☐Other (Specify)
ion of	ding h. After fune		27. Manner of Death 1 X Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Injury	28c. Injury at Work? M 1 Yes 2 No	d. Describe how in	jury occurred
Division	el or Attens s after deatl il Director: id in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, street, building, etc. (Specify)	factory, office 28	f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ite)
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death oc control on the basis of examination and/or invest and manner stated.	curred at the time, date and place, and digation, in my opinion, death occurred	d due to the cause at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
)_	To the within 2 To the complete	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
	8		30. Name and address of person who completed cause of death (Item 23a) (Type, Print TSION BERHANE 3001 HOSPIT	TAL DR	CHEVERL	10/31/05 1, MD 20185
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) NOV 0 4 2005 32. Regrar's Signature	Me		,

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Shirley Alexandria Baldwin October 31, 2005 4:20 P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9649 Reach Road Potomac Montgomery If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, July 14, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 217-34-2301 81 Yrs 1924 Canada Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in then "neturel", or iteme 23s or 28s-f show the Medical Exerciper must be notified at 1 ☐ Yes 2 No Maryland Montgomery Potomac Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9649 Reach Road 20854 United States Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White δ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) National Institutes other than Elementary/Secondary (0-12) College (1-4or 5+) of Health Registered Nurse permit. Pages 1 end 2 should be filt Department of Health and Mental Hy Important: if Item 27 Is marked oth eny lighry or other treumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Roland Lewis Isabelle Frances Bayer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances E. Baldwin-Davison / Daughter 9649 Reach Road, Potomac, Maryland 20854 20b. Place of Disposition (Name of Montgometry, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State November 2. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2005 Crematorium, Inc. 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature Fuheral Service Licensee M01353 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Lung Cancer 3 Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner the attending physicien and ched for use as the burial-transit The law requires thet the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 3 Ectopic pregnancy signed by the atte Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 M Probably 4 ☐ Unknown Deed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificete 1 ☐ Yes 2 No 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) ၉ 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA herel Director: After the filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide To the Hospital o within 24 hours af To the Funerel Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and reanner stated. 29a. Certifier 29b. Signature and title bt certifier, 29d. Date signed (Month, Day, Year) 29c. License number D23783 November 1, 2005 t 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 Daniel J. Esposito, M.D. 5530 Wisconsin Avenue Suite #1400, Chevy Chase, MD. 20815 31. Date filed (Month, Day, Year) NOV 0 4 2005 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Dorothy H. Coady 1:45 P M November 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Worcester If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 17,1928 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) 1□M 2 1 F Months Days Hours Min Yrs. 219-22-1092 Director Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other then "neturel", or Items 23a or 28a-f show treumatic event, the Medical Examt or must be notified at 1 ☐ Yes 2 X No Directo Sussex Delaware Selbyville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 37425 Hill Cut Drive 19975 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: ð Specify White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other then "net any injury or other treumatic event, the Medica once. Elementary/Secondary (0-12) College (1-4or 5+) Administrative Clerk Health Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Hartman Alice Doonan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Coady (Husband) 37425 Hill Cut Drive Selbyville, Delaware 19975 Baltimore, I 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Ø Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Garrison Forest 11-8-2005 Owings Mills, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility. Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave Catonsville, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician 065 pulmarica Chronic /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit be execu Due to (or as a consequence of) P.O. Box 68760 ian/Medicai as the l IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) Physici 4☐Pregnant at time of death 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 1√0 2 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: After or Attending (Month, Day Year) 5 Pendina 1 Hatural death. investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after death 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

17/1928

oady, Dorothy

distrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

	an	Decedent's Name (First, Middle, I	11	1				2. Date of Month	Day	Year	3. Time of Dear
/Medic	cal	Annie Bo	1 -	ter				Oct	29	2005	02 101
Examir	ner	4a. Facility Name (If not institution, g University of Ma				y, Town, or Baltim	Location of De	ath	4c. 0	County of Death	
uneral			3. Sex 7.	Age (In yrs. last b	oirthday) If Und	ler 1 Year	If Under 24 H		Birth		place (State or For
rector		220-36-4463	1□M 2 X F	64	Yrs. Months	s Days	Hours Mi		Day, Year) 24–40	Cou	S.C.
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ode la	5	_		100. 01.9, 10							1 X Yes 2 □
7.28a-	rect	Md. NA 10e. Street and Number	·		Baltimo	re Zip Code			10g. Citiz	en of What Cou	ntry?
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eme er m	Iner	11. Marital Status	12. Was Decede Armed Force	ent Ever in U.S. es?	13. Was Dec	edent of His	spanic Origin? n. Mexican. Pui	(Specify Yes or lento Rican, etc.)		4. Race - Ameri Black, White,	
or it	y F.	1 ☐ Never Married 2 ☐ Marned 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	-		2 X No	Specify:	, , , , , , , , , , , , , , , , , , , ,			lack
"natural", or iteme		15. Decedent's	Year or Date		a. Decedent's Us	sual Occupa	ition		16h Kin	d of Business/In	
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er the	E O	9th grade	N/A	01 54)	Self-Er	mploye	ed		Day	care Pro	ovider
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narkad o	မ	Jessie		Carte				eaner	<u> </u>		ilson
7 ie m treum		19a. Informant's Name/Relationship	р (Турв, Print)	- 12-to. 15	b. Mailing Addre				- 75	,	Code) 217
Important: if item 27 eny injury or other tro once.		TESLA futre	a - sau	20b. Place	of Disposition (N	ame of	ne Dr	Date Date		ation - City or To	ma
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eny ir		Habrille	e Gr	K gn	Gary	P. Hai	East	1 -101-	E. Nor	ce, Md.	21202 21229
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Ifer this certificate has been signed by the attending physician and ineral director, page 2 should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical	Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or c. Due to (or d. 23c. If yes, outco. 1	as a consequence as a c	e of: th 3 Ectopic 5 Other (standard) of Injury M farm, street, factoring, death occurrend/or investigation.	cause give	26. Place of D r. 4 \(\text{Nursing} \) at ? fes 2 \(\text{No} \) e, date and place inion, death occords.	24a. What was a seath (Check only 1 1 1 1 1 1 1 1 1 1	I tobacco using the state of th	Month e contribute to to No 3 Prot 24b. Were autoprior to co death? 1 Yes Other (Specific occurred)	eny Day Year the cause of death bebly 4 Unknown posy findings availa mpletion of cause (y) M. Route Number, tated. to the cause(s)
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	•	1 - State of Massate Registrar	•	artment of Healt rtificate of Dea		tal Hygier	/11115	35672
Physici	an	Decedent's Name (First, Middle, Last)		,	1		Day Year	3. Time of Death
/Medi	cal	WINIFRED L. CLEMONS 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Locat			3, 2005 4c. County of Deal	6:10 A.M
Examir	ner	STELLA MARIS HOSPICE		TIMONIUM			BALTIMO	
Funeral	-57		(In yrs. last birthday)	If Under 1 Year If Un Months Days Hou	nder 24 Hrs. 8. E	Date of Birth Month, Day, Yea	ar) 9. Birt	thplace (State or Foreign
Director		218-18-7553	80 Yrs.		1	Month, Day, Yea 1/3/1925	MA	RYLAND
/land			10c. City, Town or Lo	ocation				10d. Inside City Limits
a-f sh	ctor	MD BALTIMORE	TIMON	ITUM				1 ☐ Yes 2X No
vith the	Dire	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Co	ountry?
eath v	Funeral Director	2300 DULANEY VALLEY ROAD A 11. Marital Status 12. Was Decedent E		21093	c Origin? (Specify	Yes or No-	USA 14. Race - Ame	erican Indian.
or Item		Armed Forces? 1 Never Married 2 Married 1 Yes 2X No	o	Was Decedent of Hispanic If Yes, specify Cuban, Mex		n, etc.)	Black, Whit	
ural', c	d by	3X Widowed 4 □ Divorced If Yes, Give Year or Dates:			ecify:			HITE
U KIKI 2-0030 filed within 72 hours after death with the Maryland Hyglene ther than "natural", or Iteme 23a or 28a-1 show ther, the Modical Examinar mart be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during i DO NOT use retired)	most of working	16b.	. Kind of Business	/Industry
d withi	ошо	Elementary/Secondary (0-12) College (1-4or 5+	-)	IEMAKER		0	WN HOME	
abe filed ontal Hyg ed othe	Be C	17. Father's Name (First, Middle, Last)			Mother's Name (Fin			
id yidilu ZIZIOOOOO 2 should be filed within 72 hours after death with the Marylan and Mental Hygene. Is marked other than "natural", or iteme 23e or 28e-1 show aumatic event, it a Medical Examinar canal be notified at	To	EDWARD MALONEY			MARY ALIC			
d 2 sh d 2 sh th and th and 7 Is m traum		19a, Informant's Name/Relationship (Type, Print) CHARLES S. MONTGOMERY/SON		ing Address (Street and Nu				2ip Code) 635
s 1 an F Heal Rem 2 other	1	20a. Method of Disposition	20b. Place of Dispo	osition (Name of	Date		Location - City or	
Page:		1	SACRED A	matory of other place) EART OF EMETERY	11/7/20	05 D	UNDALK,	MD
perfull Offe, Mary fall of ALZ 13-0030 permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla. Department of Health and Mantal Hygiene. Importent: If Item 27 is marked other than "natural", or iteme 23a or 28a-1 show any injury or other traumatic event, its Modical Examinar mant be notified at once.	I	21. Signature of Fix eral Service Licensee	2	2. Name and Address of F				COLUMN TO SELECT
		23a. Part I. Enter the disease, or complications that caused t		8521 LOCH RA			ON, MD	21286 Approximate
		shock, or heart failure. List only one cause on each line).	ter the mode of dying, such	in as cardiac or res	pratory arrost,		Interval Between Onset and Death
Physician /Medical		disease or condition a. LIVER	cancer consequence of):					
Examiner		Sequentially list conditions.						
ed sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	consequence of):					
execut and al-trar	Examlner	that initiated events c.	consequence of):					-
The Cords, F.O. BOX 60/00, The law requires that the death certificate be executed at has been signed by the attending physician and page 2 should be detached for use as the burial-transit	cal	d						
O. BOX 00 he death certifical r the attending phy		IF FEMALE:						
DOX sath cer attendir for use	Physician/Med	23b. Was decedent pregnant in the past 12 months?	Petal death 3[☐Ectopic pregnancy ☐ Other (specify)			23d. Date of de Month	livery Day Year
the d	yslc	1 ☐ Yes 2 🛣 No 9 ☐ Unknown 9 ☐ Unknown	ine or death - 5t					
cords, F.C. wrequires that the deben signed by the should be detached	by Pt	Part II. Other significant conditions contributing to death but	t not resulting in the t	underlying cause given in P	Part I.	23e. Did tobacc	o use contribute to	the cause of death?
requires been sign						1 🗌 Yes	2 No 3 Pr	robably 4XUnknown
e contraction of the contraction	Completed					24a. Was an autopsy	prior to	utopsy findings available completion of cause of
						performed 1 Yes 2 X		2 □ No
OI VITAL Physicien: rthis certifica	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatien	nt 2 ER/Outpatie		Place of Death <i>Ch</i> Nursing Home		6 ∀ lOther (Soc	city) HOSPICE
og Phy ter this	n: T	27. Manner of Death 28a. Date of Injury				Describe how in		
Attending r death. ector: After by the fune	cation:	2 Accident investigation		M 1 Yes				
or Att or Att after d Direct in by	Certific	4 Homicide determined 28e. Place of Injur	ry - At home, farm, st (Specify)	reet, factory, office		Location (Street City or Town, St.		ural Route Number.
To the Hospitel or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.		29a. Certifier 15 Certifying Physicien: To the best of	f my knowledge, dea	th occurred at the time, dat	te and place, and	due to the cause	e(s) and manner ar	s stated.
he Ho in 24 I he Fu pletely	edical	(Check only one) 2 Medical Exeminer: On the basis of and manner stat	ed.	nvestigation, in my opinion,	, death occurred at	t the time, date a	and place, and due	e to the cause(s)
With Tot	Σ	29b. Signature and title of certifier		29c License numi	72 _j	29d. I	Date signed (Mont	
		20. Name and address of parent the completed extract the	ath (Item 22a) /Tuna		12)		11/3/0	5
1		30. Name and address of person who completed cause of de DR. TARIO MAHMOOD 2300 DI	JLANEY VAL		MONIUM, M	D 21093		
	ate	31 Date filed (Month Day Year) 82 Registral	r's Signature -					
Regist	rar	NOV 0 4 2005	It April					

DHMH 17 Rev 1/2001

NOVEMBER 3, 2005 6:10 a.m.

WINIFRED CLEMONS

Diane Coates 05-7385 AKG

50			1 - For State Registrar	State of Maryland /	Department of Healt <i>Certificate of Dea</i>		Hygiene Reg. No	CUU	35673
	Physici	an	Decedent's Name (First, Middle, Las	"/		2. Date	of Death	V Year	3. Time of Death
1	/Medic	al	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Locat	Nov	ember	2, 2005 County of Peath	10:09 A M
0	Examin	er	Maryland General H		Baltimore	2		NA	
	Funeral Director	0.00	X17-38-X175	1X Age (In yrs. last bi	rthday) If Under 1 Year If Un Months Days Hou	urs Min. 3. Date	of Birth h, Pay, Year)	42 Ma	lace (State or Foreign try)
	yland		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	m or Location			1	Od. Inside City Limits
	he Mar 8a-f al	Director	Maryland N/A	Ba	1timore				1 Yes 2 No
	with t		10e. Street and Number	tan Alle	10f. Zip Code	7	10g. Cit	izen of What Coun	try?
	er deat	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic If Yes, specify Cuban, Mex	c Origin? (Specify Yes xican, Puerto Rican, eti	or No-	14. Race - Americ Black, White,	
036	within 72 hours atter death with the Maryland ene. then "naturel", or items 23e or 28e-f ehow na Madical Examinat must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1	1 ☐ Yes 2 🕅 No Spe	ecify:		Specify: Bla	ck
21215-0036	in 72 ho	Completed	15. Decedent's Ed (Specify only highest grad	de completed)	Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired).	most of working	16b. K	ind of Business/Ind	lustry
212	filed with Hygiene. other ther	Comp	Elementary/Secondary (0-12)	College (1-4or 5+)	anitorial		Ma	1. Sports	Authority
and	d be filk antal Hy ced oth c even	Be	17. Father's Name (First, Middle, Last)	Contos	18. M	Mother's Name (First, M	iddle, Maiden	Sumanile)	J
Maryland	d 2 should be filed within 72 hours after death with the Marylar th and Mental Hygiene. 27 is marked other then "naturel", or itams 23s or 28s-f show traumatic event, the Madical Examinar must be notified at	To	19a. Informant's Name/Relationship (7	ype, Print) (mother) 191	o. Mailing Address (Street and Nu	umber or Rural Route N	lumber, City o	r Town, State, Zip	Code)
	t Health item 27 other tr		Mrs. Thelma (Loates 16	f Disposition (Name of	a Ave.	20c. Lo	alto M	$d_1 2/2/7$ wn. State
Baltimore,	Page: ent o nt: If ry or		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	ry, crematory or other place) Lu< Nom.PacK	11/7/2005	5 Ar	butus	. Md
Balt	permit. Pac Departmen Important: any injury once.		21. Signature of Funeral Service Licen		22. Name and Address of E	acility USS Fun	eral	Home P.	4
-4			23a. Part1 Enter the disease, or comp shock, or heart failure. List only of	tications that caused the death. Do one cause on each line.				racer	Approximate Intervat Between Onset and Death
	Physician /Medical		tmmediate Cause (Final disease or condition resulting in death)	a. Hyperfercive Due to (or as a consequence		otic Cound	LOVASC	elan	Onset and Death
*	Examiner	_	Sequentially list conditions, if any, leading to immediate	b	- Styllise				
y	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence	of):				
60,	ficate be executed g physicien and as the burial-transit	i Exa	resulting in death) Last	Due to (or as a consequence	of):				
68760,	= C0 m	edicai	•	d					
.O. Box	The law requires that the death certifi tie has been signed by the attending bage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☑ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of delive Month	ry Day Year
<u>α</u>	es that the de igned by the a be detached	by Ph	Part It. Other significant conditions co	ntributing to death but not resulting	n the underlying cause given in P	Part I. 23e.	Did tobacco u	se contribute to th	e cause of death?
of Vital Records,	w requir been si should l						1 ☐ Yes 2	1	. 4
Rec	The law cete has page 2	Completed					Was an autopsy performed? /es 2 □ No	prior to con dear?	osy findings available inpletion of cause of 2 No
Vital	Physician: This certificer	Be	25. Was case referred to medical examiner?	Hospitat:	0.4	Place of Death Check	only one		
	Phys this aldii	n; To	27. Mapner of Death	28a. Date of trijury 28b.	Time of 28c. Injury at	Nursing Home 5 28d. Desc	Residence ribe how intur)
Division	uttending death.	catio	1 Natural 5 ☐ Pending 2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be		M 1 ☐ Yes 2				
Divi	he Mospital or Attending in 24 hours after death. he Funeral Director: After pletely filled in by the funer	Certification;	4 Homicide determined	28e. Place of Injury - At home, to building, etc. (Specify)	arm, street, factory, office	28f. Locat City o	ion (Street an or Town, State	d Number or Rura:)	Route Number,
	e Hosp 24 hou e Fune etely fil	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of my knowledg iner: On the basis of examination ar and manner stated.	e, death occurred at the time, date nd/or investigation, in my opinion,	e and place, and due to death occurred at the	the cause(s) time, date and	and manner as standard place, and due to	ated, the cause(s)
	To the Hos within 24 hr To the Fur completely	Me	29b. Signature and title of certifier	1000	29c. License numb	ber	29d. Dat	e signed (Month, 1	Dey, Year)
	Ì.		30. Name and address of person who c	Hallan n	O.C.M.E.		Nove	mber 3,	2005
	γ\		CTROL HI	REAN Md 1	11 Penn Street,	Baltimore	, Maryl	and 2120	1
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 4 2005	32. Registrar's Signature	and a				

			1 - For State	State of Maryland /		of Health and of Oeath		2005 25671
si.		e i	Registrar 1. Decedent's Name (First, Middle, La	st)	Ochincate	or Death	Reg. 2. Date of Death	3. Time of Death
8	Physici /Medio		Florid	Clark			October	31 2005 9:11 PM ^M
	Examir		4a. Facility Name (If not institution, give	re street and number)	4b. City, 1	Town, or Location of Dea		4c. County of Death
2		j.	Sinai Hospital		Balti			NA
	Funeral Director		5. Social Security Number 6. S	Sex 7. Age (In yrs. last bit 52	Yrs. If Under Months	1 Year If Under 24 Hrs Days Hours Min		9. Birthplace (State or Foreign
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	vn or Location			10d. tnside City Limits
	a-f eho	tor	Maryland NI	A Ba	11	-6.		1 X Yes 2 No
	with the	Funeral Director	10e. Street and Number	A /2 10 1 / 2	10f. Zip	Code	10g.	Citizen of What Country?
	death	nera	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decede	ent of Hispanic Origin? (S fy Cuban, Mexican, Puer	Specify Yes or No-	14. Race - American Indian,
980	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23e or 28e-f show other traumatic event, the Medical Exemination must be notilised at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 XYes 2 No If Yes, Give Year or Dates:	1 Yes 2		то нісап, всс.)	Black, White, etc. Specify: Plack
2-0	72 ho	eted	15. Decedent's E (Specify only highest gr	ducation 16a	. Decedent's Usual (Give kind of work	k done during most of wo	irking 16b	. Kind of Business/Industry
21215-0036	filed within Hygiene. other then "	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	DI SAK	e retired)	9	NIA
	be filed tal Hyg d other	Be	17. Father's Name (First, Middle, Last			18. Mother's Na	me (First, Middle, Maid	den Sumame)
Maryland	2 should be f and Mental H is marked of aumatic eve	٢	Edward D	Clark Sr.	h Admillion Automon	Veri	nce	lurner
Mai	and 2 sh eaith and m 27 is r		19a. Informant's Name/Relationship	Type, Print) (Brower) 19t	HIIQ K	(Street and Number of H	A VO	ty or Town, State, Zip Code)
ore,	ges 1 and 2 t of Health if Item 27 or other tra		20a. Method of Disposition		of Disposition (Namery, crematory or oti	e of	Pate 20c	Location - City or Town, State
Baltimore,	nit. Pages partment of cortent: If Its Injury or o		1 Durial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	W) Gary		orest 11/8	12005	Wings Mills, Md.
Bal	permit. Pages Department of the Importent: if Ite eny Injury or of once.		21. Signafore of Funeral Service Lice	L. Russ	Joseph 2222 W	Address of Facility LRUSS FU	meral Ho	me, P.A.
e d			23a. Part V. Enter the disease, or conshock or heart failure. List only	plications that caused the death. Do one cause on each line.	not enter the mode	of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between
1	Pnysician /Medical	8	Immediate Cause (Final disease or condition resulting in death)	a Antenosclero	tic Carl	ougala	Viscaire	Onset and Death
	Examiner			Due to (or as a consequence	of):			
1	P ##	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence	of):			
A)	icate be executed physicien and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequence	of):			
68760,	e be e /sicien e buris	edicai E	· ·	d				
_				- U.				
Вох	death certifi e attending I id for use as	lan/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. tf yes, outcome of pregnancy 1 Live birth 2 Fetal death				23d. Date of delivery Month Day Year
o.	0 0	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown	5 ☐ Other (spe	нсіту)		,
S, P	ss this gned se de	by P	Part II. Dther significant conditions			use given in Part I.	23e. Did tobacc	to use contribute to the cause of death?
ord	w require been si should {	eted	tallinge &	enal Disease			1 🗆 Yes	No 3 Probably 4 Unknown
Vital Records,	: The law cate has b page 2 s	Completed	-				24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
tal			25. Was case referred to medical			26 Place of Do	1 ☐ Yes 2	
f Vi	d in	To Be	examiner? 1 X Yes 2 □ No	Hospital: 1 ☐ Inpatient 2€ER/O	utpatient 3□ DOA	Cther	dome 5 Residence	6 □Other (Specify)
n of	ding Ph h. After th funeral		27. Manner of Death 1 ■ Natural 5 □ Pending			tc. Injury at Work?	28d. Describe how in	
Division	Attendideath.	Icati	2 Accident investigation 3 Suicide 6 Could not be		M Street factory	1 ☐ Yes 2 ☐ No	28f Location /Stroot	and Number or Rural Route Number,
Θį	i i d	Certification:	4 Homicide determined	building, etc. (Specify)	ann, street, ractory,	Onice .	City or Town, St	
	To the Hospital of within 24 hours at To the Funerel D completely filled in	Medical	29a. Certifier 1 ☐ Certifying Pl (Check only one) 2 Medical Exer	nysician: To the best of my knowledge niner: On the basis of examination an and manner stated.	e, death occurred and/or investigation,	t the time, date and place in my opinion, death occi	e, and due to the cause urred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
	To the within 2 To the complet	Me	29b. Signatore and title of certifier	^	29c.	License number	29d.	Date signed (Month, Day, Year)
			D Cirken	W		O.C.M.E.	No	ovember 1, 2005
	7,			completed cause of death (Item 23a)		Donn Ctree -		
99 N	S Sta	te	31. Date filed (Month, Day, Year)	32. Degistrar's Signature	TIT	reim Street	- Dallimor	re, Maryland 21201
	Registr	-	NOV 0 4	2005	Lugar S. S			

		•	For State Registrar		State	of Ma	aryland		artment of hartificate of				giene (005	35675
	Dhuciei	20	Decedent's Name	,								2. Date of Dea		Year	3. Time of Death
	Physici /Medic	al	MILD 4a. Facility Name (h				ick		4b. City, Town, o	or Location	of Dooth	11	01	2005 unty of Death	0150 AM
	Examin	er			IS BAYY		GARE	GNIER	BALTI			D	_	ALTIM	
	Funeral Director		5. Social Security N 2 13 - 16-		6. Sex 1 ☐ M 2 🔀 F	7. Age	9 (In yrs. Ia 84	st birthday) Yrs.	If Under 1 Year Months Days	If Unde Hours	Min.	8. Date of Birth (Month, Day	Year)	Cou	place (State or Foreign ntry) imore, MD
	land land		Usual Residence of 10a. State	Decedent 10b. County			10c. City,	Town or Lo	cation				1		10d. Inside City Limits
	Mary B-f eh	tor	MD	How	ard		Co1	umbia							XX Yes 2□No
	or 28	Director	10e. Street and Nur						10f. Zip Code					of What Cou	ntry?
	leath v	Funeral	5860 Thu	nder H	ill Koad 12. Was De	cedent l	Ever in U.S	. 13. V	21045 Was Decedent of R	Hispanic C	rigin? (Spe		USA	Race - Ameri	can Indian.
980	172 hours after death with the Maryland "naturel", or Items 23a or 28e-f ehow idical Examinar must be rodified at	by	1 Never Marri		ried 1 Tyes	Forces? Sive		H	Yes, specify Cub	an, Mexic	an, Puerto	Rican, etc.)		Black, White,	
5-0	"natur	eted	(Spec	15. Deceden	it's Education st grade completed	d)		(Give	lent's Usual Occup	durina mo	st of worki	ing	16b. Kind o	of Business/Ir	dustry
21215-0036	filed within 7 Hygiene. other than "r sent, the Med	Completed	Elementary/Seco	ndary (0-12)	College	(1-4or 5	+)		oo NOT use retire atric Num	,			Hospi	ital	
pu	m = 0 5	Be C	17. Father's Name (Last)	-						(First, Middle,	Maiden Sur	name)	
Maryland	should be nd Mental marked o	2	Chester					405 Maille	- 4 (04	<u> </u>		kiewicz			0.43
Mai	2 6 8 2		19a. Informant's Na Antonia		i (daught	cer)			g Address <i>(Street</i> Thunder					MD 210	
Baltimore,	es 1 and 2 of Health if item 27 I		20a. Method of Disp	osition	3 □Removal from		20b. Pla	ce of Dispos netery, cren	sition (Name of natory or other pla	сө)		Date	20c. Locati	on - City or T	own, State
tim	permit. Pages Department of t Importent: If it any injury or o		` 4 □Donation	5 Other (S	Specify)	II Otalo	Nat		Cremator	- 1				Church	
Bal	permit. Departr Importe any inje		21. Signature of Fu	∑ (. :	tacky	no	~	55	Name and Address Name and Address Name	Kno1	ls Rd	., Co	lumbia	Homes,	
			23a. Part1. Enter the shock, or head immediate Cause (rt failure. List	r complications that only one cause or	each lin	10.		_			or respiratory ari	rest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)		a Due t		K K II		5 Dise	ASE	-			-	>20 years
	Examiner		Sequentially list cor	nditions,	b										70.
	nsit	Examine	if any, leading to im cause. Enter Unde	mediate rlying	Due t	o (or as	a conseque	nce of):							
oʻ	icate be executed physician and s the burial-transit		that initiated events resulting in death) L		c Due t	o (or as	a conseque	nce of):							
68760,	cate be ohysicia the bu	dlcal			d		-								
Box 6		au i	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, o								23d.	Date of delive	erv
o.	0 0	Physician/M	in the past 12 1 Yes 2	months?		gnant at	2 ☐ Fetal of time of dea		Ectopic pregnanc Other (specify) _	У				Month	Day Year
s, P	es that igned b	by Pl	Part II. Other signif	icant conditi	ons contributing to	death be	ut not result	ing in the ur	nderlying cause gr	ven in Parl	l.	23e. Did to	bacco use d	contribute to t	he cause of death?
ord	w requir been si should											1 🗆 Y			
al Record	The far ate has page 2	Completed						-				24a. Was a autops perfor	sy	prior to co death?	opsy findings available impletion of cause of
Vital	9 9 9	o Be	25. Was case reference examiner?	_	Hospital:	Innatie	nt 2∏E	R/Outpatien	t 3 DOA Ott	200		n <i>(Check only or</i> me 5 ☐ Resid		Other (Special	6,1
n of		\vdash	27. Manner of Death		28a. Dat		y 2	8b. Time of Injury	28c. Inju Wo			28d. Describe h			<i>y</i> 7
Division	tendir death. tor: Af the fur	catic	2 Accident	investi 6 🗆 Could	gation not be				M 1	Yes 2		204 Landing (C			-1 C
DİX	el or Attendi after death l Director: A d in by the f	Certification;	4 Homicide	determ	nined 286. Fla	lding, etc	c. (Specify)	ie, iarm, stre	eet, factory, office			City or Tow		imber or Hura	al Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical C	29a. Certifier (Check only one)	1 Certifyir 2 Medicel	ng Physician: To the Examiner: On the	he best of basis of unner sta	examination	ledge, death on and/or inv	occurred at the ti restigation, in my	me, date a opinion, de	and place, a	and due to the c ed at the time, d	ause(s) and late <i>a</i> nd plac	manner as s ce, and due to	tated. the cause(s)
	To th within To th comp	Me	29b. Signature and	itle of certifie	r		~		29c. Licens	se number		2	9d. Date sig	gned (Month,	
)	. 4		}	no	nas	Pr	w	ca	- D	2	13	54	No	veml	en 1, 2005
	17		30. Name <i>a</i> nd address					23a) (Type, I		BA	LTIM.	ORE, M	ND	2/22	-4
State Registrar NOV 0 4 2005 32. Figistrar's Signature															

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 23a, 25, 27, 28a-f per MF, C849, 11/02/05dhb 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2005 Physician Sept. 23, Christopher Duvall DeVier 11:35pm M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Taneytown Carroll Lorien Taneytown Nursing Home If Under 24 Hrs. Birthplace (State or Foreign Country)
 VA If Under 1 Year 8. Date of Birth (Month, Day, Year)
July 2, 19 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1□M 2□F 1936 219-34-1828 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location in than "natural", or flams 23a or 28a-f show the Medical Examinet must be notified at Windsor Mill 1 □Yes 2X1No MD Baltimore Funeral Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 8703 Windsor Mill Road 21244 death 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 □Yes 2 □ No If Yas, Give Year or Dates: 1955-57 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Be Completed by 3 V Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Electric Tester Utility Company traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fand Mental H Helen Margaret Miller s 1 and 2 should be f Health and Menta item 27 is marked Dr. Charles Wallings DeVier, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Mrs. Pamela Chadden (Daughter) 29 Trenton Ct., Littlestown, PA 17340 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of t permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State All County Cremation 9/26/2005 Sykesville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ligensee HANGHT FUNERAL HOME & CHAPEL, PA (Box 195) plean & Yauge Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or reso ratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PREUMONIA /Medical Due to (or as a consequence of): Examiner DYSTHACIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Josephson or jury that initiated events resulting in death) Last Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAMINER certificate be executed burial-tran Due to (or as a consequence of) .O. Box 68760, physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐ Pregnant at time of death 5 Cther (specify) signed by the a 1 TYRS 2 TNo 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Hypertensive Completed been Atherosclerotic cardiovascular disease; Subdural 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed? hematomas (Acute and Chronic) 1 Yes 2 No 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2€/o Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred filled in by the funeral 27. Manner of Death 28c. Injury at Work? Certification: 5 Pending Motor vehicle collision and 1 ☐ Yes 2 XNo Unknown ^M 2X Accident investigation Unknown 28f. Location (Street and Number or Rural Route Numb Falls
City or Town, State) 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide street and at home Pennsylvania and Maryland within 24 hours a To the Funeral C completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 9-23-05 D 43643 ww 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21787 I kinds or . transcriben ino A. TATE a.D 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

DITIVIT 17 NOV 1/2001

			1 - For State Registrar	State of	Marylan			nt of He te of D			R	eg. No.	005	35677
	Physici	an	Decedent's Name (First, Middle, La DARYL D.	DAV I							Date of Dea Month	Day	Year	3. Time of Death
	/Medio	al	4a. Facility Name (If not institution, give				4b. Cit	. Town. or l	Location of E)ctober		2005 ounty of Deat	10:44 a.Mn.
	Examir	ier	University Shock		0.7			ltimo						
	Funeral Director		5. Social Security Number 212-92-5073 6. 9	Sex 7. 1□XM 2□ F	Age (In yrs. 28	last birthday) Yrs.	If Und Month	er 1 Year Days	If Under 24 Hours		Date of Birth Month, Day 2/24/1	977	9. Birt Co	hplace (State or Foreign nuntry) MD
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Marylan i-f show lied at	tor	MD		BA	LTIMOR	E							1 XYes 2 No
	with the a or 28s	Direc	10e. Street and Number 2440 FREDERICK A	VENUE			10f. Z	ip Code 2122	23		1	0g. Citize	n of What Co USA	ountry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any Injury or other traumalic event, the Medical Examt must be notified at once.	by Funeral Director	11. Marital Status 1☆ Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceded Armed Force 1 Tyes 2 If Yes, Give Year or Date	es? □¥No					n? (Specif Puerto Ric	y Yes or No- can, etc.)		Race - Ame Black, White Decify: BL	e, etc.
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d 21	Hygie Hygie other t		17. Father's Name (First, Middle, Last	")			- 00		18. Mother's	s Name (F	irst, Middle,			
Maryland	fental fental rked c	To Be	DARRYL DAVIS							KAR	EN V.	KEITH	I	
lary	and No.	-	19a. Informant's Name/Relationship	(Type, Print)			•			or Rural F	Route Number	, City or T	own, State, 2	
	fealth rm 27 her tr		ANTOINETTE DAY/S	ISTER	20b B	Place of Dispo			ERICK	AVEN	UE, BA			
Jore	ages 1 nt of H : If ite		20a. Method of Disposition 1 △ Burial 2 □ Cremation 3 □		ate C	emetery, crei	matory o	other place	!				tion - City or	
Baltimore,	permit. Pa Departme Important any Injury		4 Donation 5 Other (Special 21. Signature of Funeral Service Lice		M'	r. ZIO	2. Name		s of Facility		S A. M	ORTON		NS F.H., INC
	-81		23a. Part. Enter the disease, or con	nplications that cau	sed the deat	h. Do not en					T, BAL espiratory arr		MD 212	Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)		shot u	soun C	9 0	f to	Y 60					Interval Between Onset and Death
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8760,	the bur	dical	•	d										
Box 6	ath certif ttending or use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2∏Feta ntattimerofd	Ideath 3	⊒Ectopic ⊒ Other (pregnancy specify)				230	d. Date of del Month	ivery Day Year
ds, P.0	uires that the des signed by the a id be detached f		Part II. Other significant conditions	contributing to dea	th but not res	ulting in the u	ınderlying	cause give	n in Part I.			v		o the cause of death?
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of Vital	ician: Th certificate rector, paç	BeC	25. Was case referred to medical examiner?	_ iiii _ 82					26. Place o	f Death (0	Check only or		142163	20,10
> <u>></u>	Physician: this certific ral director,	ုင္	1X Yes 2 No	Hospital:		ER/Outpatie	-		4 🗆 14015	-	5 🗆 Resid			cify)
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			I hig his,	mis										
	,7		30. Name and address of person who	completed cause	ol death (Iter	n 23a) (Type,	, Print)	III P	enn St	treet	Balt	imore	e, Mar	yland 21201
3	St	ate	31. Date liled (Month, Day, Year)	32 Re	gistrar's Signa	ature	and .	,						
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			For State Registrar	State of	of Marylan		artment of H		and Mer		ene g. No. 🤈 (105	25670
	Physicia	an	Decedent's Name (First, Middle, L.		·-					Date of Death Month ovember	Day	Year 005	3. Time of Death O
	/Medic Examin		Ann Y. Duva		mber)		4b. City, Town, or	Location of		Vember		ity of Death	
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	deat	Funerai	11. Marital Status		edent Ever in U. orces?	S. 13.	Was Decedent of H	lispanic Ori	gin? (Specify i, Puerto Ric	y Yes or No- an, etc.)		ace - Amer lack, White	ican Indian, . etc.
36	filed within 72 hours after death with the Maryland Hygiene. the than "natural", or Itama 23a or 28a-f show in, Ira Madical Examinari suat be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced		2 ⊋ No ive		1 ☐ Yes 21X No				Spec		
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Ĕ	Pages tment of tant: If It jury or o		4 □Donation 5 □ Other (Spe	cify)	Nat	ional	Cemetery		, 200.	- total			irginia
Ball	permit. Page Department of Important: If any Injury or		21. Signature of Funeral Service Lin	ensee	M01353	Be Be	thesda-Cl thesda,	nevy (Mary1	Chase and 20	814-35	7557W	iscon	neral Home sin Avenue
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0	ding h. After funer	tion	1 ⊠ Natural 5 ☐ Pending 2 ☐ Accident investiga	(Mo	nth, Day Year)	Injury	Wo	rk? ∣Yes 2.⊟			,,		
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	To the Hospital within 24 hours a To the Funeral I completely filled	cai		caminer: On the			th occurred at the time to execute the street of the stree						
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	- 5 + 5		10/1A	1h		>	700	3048	24	N	ovembe	r 2.	2005
	15		30. Name and address of person w				, Print)						
	\		Charles A. Umose					ie #10	1, Be	thesda	, Mary	land	20814
	St Regist	ate rar	31. Date filed (Month, Day, Year) NOV 0 4 200	5	Registrar's Gign	ature	V						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Cragin W. Donaldson, Jr. 11:00 AM October 31, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Takoma Park Montgomery Washington Adventist Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 11, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Months 1⊠ M 2□ F 577-52-5359 Yrs. Washington, D.C 81 May Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: if item 27 is marked other then "netural", or iteme 23a or 28a-f show injury or other traumatic event, the Mucilical Examinar must be notified at 1 ☐ Yes 2 1 No Director Maryland Montgomery Clarksburg 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 23620 General Store Drive 20871 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) Was Decedent Ever in U.S. Armed Forces? Race - American Indian, 11 Marital Status Black, While, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: Specify: White à 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Self Employed 12 Trave1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: if item 27 is marked other any lighty or other traumatic event other. Cragin W. Donaldson, Sr. Margaret Griner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy S. Donaldson/Wife 23620 General Store Drive, Clarksburg, Maryland 20871 20b. Place of Disposition (Name of cemetery crematory or other place)
Gate of Heaven 20a. Method of Disposition Date 20c. Location - City or Town, State November 4, 1 Burial 2 Cremation 3 Removal from State Silver Spring, Maryland 4 □ Donation 5 ☑ Other (Specify Entombment 2005 Mausoleum 21. Signalure of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. M00198 300 West Montgomery Ave., Rockville, MD 20850-2805 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** OFONAN 31) years /Medical Due lo (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): attending physicien for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 2 110 1 Yes to the Hospital or Attending Physician: after death.

Director: After this certification by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Tes 2 □ NO 1 Thpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury Certification: 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 Tes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 | Homicide within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 23a) (Type, Print) Bluel, Suite 125, Rockulle, MD mkinin 21 32. Regislrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 4 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 0 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Jime of Beam Month **Physician** Richard J. Doerner 2:40 PM November 2, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Nursing Home Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F 82 Director 578-22-2738 July 2, 1923 Indiana Usual Residence of Decedent iled within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State or 28a-f show Rockville 1X Yes 2 □ No Maryland Montgomery Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? rthan "natural", or Items 23s or the Medical Examinar must be a 703 Robert Road 20850 United States Completed by Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. United States Elementary/Secondary (0-12) College (1-4or 5+) Cartographer Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be fi Sylvia Wilson Harry A. Doerner ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Heelth a Frances Edna Doerner / Wife 703 Robert Road, Rockville, Maryland Item 27 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Peges 1 Gate of Heaven November 7, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Department of Important: If any Injury or once. 2005 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 21. Signatur of Funeral Service Lic-Robert A. Pumphrey Funeral Home/Rockville, M01420 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Pneumonia 2 Days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner sicien and burial-transit death certificate be executed Due to (or as a consequence of) physicien Physician/Medical d The in use as IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Senile Dementia, Congestive Heart Failure 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2X No မှ his After thi funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; Attending 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funerel Direct completely filled in by 4 | Homicide ö Hospitel 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D31839 November 3, 2005 usti 30. Name and address of person of continued cause of death (Item 23a) (Type, Print) Christopher Dunford, M.D. 615 West Montgomery Avenue, Rockville, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 0 4 2005

DHMH 17 Rev 1/2001

Box 68760,

P.0.

Division of Vital Records,

			For State Registrar	State of Marylan	d / Depa	artment of F	Health and M		giene 005	35681
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			1 - For State Registrar			rtificate of			2005	35683
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Baltimore,	permit. Pages Department of I Important: If its any injury or o		21. Signature of Funeral Service License	9			ss of Facility CH	ARLES S.	ZEILER &	SON, INC.
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•	*	1	30. Name and address of person who co	moleted cause of dea	th (Item 23a) (Type	Print) -	3000	, 0	cioser 3	1 2001
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	1 - For State Registrar		State of	Marylan		artment of F tificate of			giene Reg. No.	005	3568	4
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i.e	11. Marital Status 1 □ Never Married	2N Married	12. Was Dece Armed For 1 ☐ Yes		.S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin' an, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	14	Race - Amer Black, White		
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Ł	19a. Informant's Name/F				1.			r Rural Route Numbe	_			
	Joseph M.]		spand	20h F				ane, BR416		ONSVILL ation - City or T		.228
	1 □ Burial 2 🛣 Cre	emation 3 🔲		nate		sition (Name of natory or other plac						
	° 4 ☐ Donation 5 ☐ 21. Signature of Fyneral			Met		matory, . Name and Addre				timore,		
	Elwa	MIT	nul	C:		ALEGE AL	100000000000000000000000000000000000000	Cremation				•
	23a. Part1. Enter the dis	sease, or mp	CACHIK dications that ca	used the deat	-	99 Frede:				MD 21	Approximate	
	shock, or heart fail Immediate Cause (Final	ure. List only o	one cause on ea	ich line.		_				1	Interval Between Onset and Deat	n th
	disease or condition resulting in death)		a. DON	or as a conseq	mence of).	w tailu	ra				weeke	>
Jer J	Sequentially list condition if any, leading to immed	ns, iate	Mue		tolas	ic syr	drom	ne		- J.	Years	
Examiner			c	or as a conseq	uence of):							
Medicai			d				- dutinity		- 1			
Physician/Med	23b. Was decedent preg in the past 12 mont 1 Yes 2 No 9 Unknown	gricuit		nth 2 ∏ Feta unt at time of d	Ideath 3□	Ectopic pregnancy Other (specify)			23	d. Date of deliv Month	ery Day Year	
		conditions co	ontributing to de	ath but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use	contribute to	he cause of death	17
d by								1□Y	es 2	No 3 ☐ Pro	bably 4 🗆 Unkn	iown
ompieted							. <u> </u>	24a. Was a autop	sy	24b. Were auto prior to co death?	opsy findings avail empletion of cause	lable of
O								1 ☐ Yes	2 No	1 🗆 Yes	No No	
Be	25. Was case referred to examiner?	<u> -</u>	Hospital:			Oth	or	Death (Check only or				
5. To	1 ☐ Yes 2 ☐ No 27. Manner of Death		28a. Date o	f Injury	ER/Outpatien 28b. Time of	28c. Injun	y at	ig Home 5 Resid		Other (Speci	(y)	
tion		Pending investigation	(Month	, Day Year)	Injury	Worl	k? Yes 2 □ No	2. 2. 2. 2. 3. 11				
fica	3 🗍 Suicide 6	Could not be	28e. Place	of Injury - At he	ome, farm, str	eet, factory, office				Number or Rur	al Route Number,	_
Certification:	4 Homicide	GO.OHIIII IOU	buildin	g, etc. (Specif	y)	,		City or Tow				
edical C	29a. Certifier (Check only one)	Certifying Phy Medical Exam	/sician: To the iner: On the ba and mann	sis of examina	wledge, death tion and/or inv	occurred at the timestigation, in my o	ne, date and pl pinion, death o	ace, and due to the occurred at the time, o	ause(s) ar late and pl	nd manner as s lace, and due t	stated. the cause(s)	
Me	29b. Signature and title of	of certifier				29c. License	e number	2	9d. Date s	signed (Month,	Day, Year)	
	The 1. 15	/				D 34	209	7	40010	-ahac	N3 200	25
	100112.11	-				10,71	$r \cap r$		A I SIES	AT WELL		
	30. Name of d address of	f pers in who c	ompleted cause	of death (Item	n 23a) (Type,	Print)	NO I			77 C-41	00 0	
	Mylamo	Diper	ster 1	IT OM	n 23a) (Type,	Print) den C	noice	Ln Co	about	ouille	2 MD	
State istrar	30. Name and address of My Month, Data filed (Month, Data)	Diper	ster 1	of death (Item	n 23a) (Type, Moriture	Print) den Cl	hoice	10 Cd	than	sville	2 MD	

			1 - State Amend Item#5	State of Man per FH G8	(land)/089	ortment of rtificate of	Health f Death	and Mental F	lygien	005	35685
			1. Decedent's Name (First, Middle, Last,			· · · · · · · · · · · · · · · · · · ·		2. Date of Month	Death		3. Time of Death
П	Physici /Medic		Selma Fenari					Novem	ber 2	² , 2005	6:00 A.M
	Examir		4a. Facility Name (If not institution, give			4b. City, Town		of Death		c. County of D	
			8911 Reisterstown		in come do ná folimbrato co	Pikesv		24 Hrs 0 Date of	Dieth B	saltimo	re County
	Funeral Director			744	n yrs. last birthday) 31 Yrs.	Months Day		Min. 8. Date of (Month, Jan •	Day, Year	24 Ts	Birthplace <i>(State or Foreign</i> Country) tambul,Turkey
	D		Usuel Residence of Decedent					1 10 0.000	,		
	arylan show	Ļ	10a. State 10b. County		Oc. City, Town or Lo						10d. Inside City Limits
	28a-f	Director	Maryland Baltimor	e County	Pikesv				10- 0	1414 144	1 Yes 2 No
	with with the party			n Dood Ant	120	10f. Zip Code				itizen of What	-
	Jeath ms 23	Funerai	8911 Reisterstow	12. Was Decedent Eve			21208 f Hispanic Oi	rigin? (Specify Yes or n, Puerto Rican, etc.)		ted St	merican Indian,
9	be filed within 72 hours after death with the Maryland tall Hyglene. Id other than "netural; or items 23e or 28e-f show event. I've Medical Examinar must be notified at	F	1 Never Married 27 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give							/hite, etc.
93	iral',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		1□Yes 2∏N	lo Specify			Specify:	Vhite
5-	"netu	Completed	15. Decedent's Edu (Specify only highest grad		/Give	dent's Usual Occ kind of work don DO NOT use reti	ne durina mo:	st of working	16b. l	Kind of Busine	ess/Industry
12	within ene. than "	duc	Elementary/Secondary (0-12)	College (1-4or 5+)		istrati		istant	Not	re Dame	e Prep School
5	filed Hygi other	Be Co	17. Father's Name (First, Middle, Last)		TAGINET	ILBULAUL	-	er's Name (First, Mide			z riep benoer
lan	Mental Merked o	To B	Sevket Namamik				Ros	e Killave			
Maryland 21215-0036	2 should be and Mental is marked (eumatic ev		19a. Informant's Name/Relationship (T)			-		er or Rural Route Nur			
	s 1 and 2 should f Health and Mer Item 27 is marke other treumatic		Charisse F. Werr				Knoll	* * * * * * * * * * * * * * * * * * *			aryland 21093
Baltimore,	Pages 1 nent of H int: If Ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F			matory or other p	· · · · · · · · · · · · · · · · · · ·	Date			or Town, State
Ë	t. Partmen		* 4 Donation 5 Dother (Specify)		-	-	-	Nov. 4,200	5 Ti	monium	, Maryland
Ba	permit. Pages Department of It Importent: If Ite any Injury or of		21. Signature of Funeral Service Licens Sang Jeb	m	P 2		Alteri Road	natives Fu Timonium		&Crema and 21	tion Ctr.,P.A
П			23a. Part1. Enter the disease, or compleshock, or heart failure. List only o	ications that caused the ne cause on each line.	e death. Do not en	ter the mode of d	ying, such as	cardiac or respirator	y arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Alzh	eimer	s Dise	ase				Onset and Death
	/Medical Examiner		Testiming in dealiny	Due to (or as a c	onsequence of):						
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a c	onsequence of):						
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	G							
o,	an an	Еха	resulting in death) Last	Due to (or as a c	onsequence of):					-21	
8760	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	dicai		d							
9	e as t	Med	IF FEMALE:								
Вох	eath certific attending pl	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	Fetal death 3	Ectopic pregnar	псу			23d. Date of Month	delivery Day Year
P.0.	at the de by the a tached	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at tim 9□Unknown	ie or death 5 L	Other (specify)			-		
	res that t igned by be detar		Part II. Other significant conditions co	ntributing to death but n	not resulting in the u	nderlying cause (given in Part	I. 23e. Di	id tobacco	use contribute	e to the cause of death?
Vital Records,	quires n sign	d by	Diabetes Melli	tus				1	Yes 2	2 □ No 3 □	Probably 4 (Maknown
CO	aw requir is been sk 2 should b	Completed						24a. W			autopsy findings available
Re	The la ate ha page 2	mo						at pe	itopsy arformed? s 2 ⊡√	death	to completion of cause of of or of the completion of cause of the cau
ita	iclan: Th certificate ector, pag	Be C	25. Was case referred to medical examiner?				26. Plac	e of Death (Check on		~	
× ×	Physiclan: this certific ral director,	은	1 ☐ Yes 2 ☑ No	fospital: 1 Inpatient	2 ER/Outpatie	II 3 DOA	Other: 4 N	ursing Home 5 Re	esidence	6 DOther (S	ipacify) ASS is ted
o u	D je	iuo	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	ear) 28b. Time o	W	lork?	28d. Describ	e how inju	ury occurred	
Division of	Attending r death.	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury	- At home farm st		Yes 2		(Street a	nd Number or	Rural Route Number.
Di≤		Certification:	4 Homicide determined	building, etc. (Specify)	reet, factory, offic	•		Town, Stat		raia rodio rambor,
	To the Hospitel or within 24 hours after To the Funeral Dillicompletely filled in		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best of n	ny knowledge, deat	h occurred at the	time, date a	nd place, and due to the	he cause(s	s) and manner	as stated.
	To the H within 24 To the F complete	Medical	one)	and manner stated	i.			attroccured at the th			
1	To To	2	29b. Signature and title of certifier	7. O	2		nse number	76		• .	onth, Day, Year) 3, 2005
'	10		Daven L. E			_	-786	1	1000	THE !	
	\		30. Name and address of person who con Karen L. Babit	, M.D. , 25	Moin six	Print) (eet, Su	11te 20	o, Peister	500	n, MD	21136
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	AR-A					

ORIGINAL

		_	State of Maryland / Department of Health and No. 1 State of Maryland / Department of Health and No. 28a-f per ME, 6848, 10/25/05dhb Certificate of Death	/lental Hyg	iene 005 35686
	Physici /Medic		1. Decedent's Name (First, Middle, Last) EUGENE FISHER	2. Date of Deat Month	h Day Year S 22 A, M,
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. Facility Name (If not institution, give street and number) 4c. Facility Name (If not institution, give street and number) 4c. Facility Name (If not institution, give street and number)		4c. County of Death
	Funeral Director		5. Social Security Number 6. Sex 1 Months Days Hours Min. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birthplace (State or Foreign Country) W. Virginia
	r 28a-f show		10a. State 10b. County 10c. City, Town or Location MD BATI MORE 6len ARM		10d. Inside City Limits 1 ☐ Yes 2 🔀 lo
	ath with the 23a or 28a ust be noti	Funeral Director	10e. Street and Number 11430 Glen ARM Rd. Unit 134 21057	10	Og. Citizen of What Country?
36	or items	y Funera	11. Marital Status 12. Was Decedent Ever in U.S. Amped Forces? 1 Never Married 2 Married 11. Never Married 2 Married 12. Was Decedent Ever in U.S. Amped Forces? 13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
15-0036	~ 3	Completed by	15. Decedent's Education (Specify only highest grade completed) Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of work	din g	16b. Kind of Business/Industry
d 2121	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the M	Be Comp	Elementary/Secondary (0-12) College (1-40r5+) Investigator Tobacc		State of Maryland.
Maryland	s 1 and 2 should be filed f Health and Mental Hyg item 27 is marked othe other traumatic event,	ToB	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rur	Bee Tal Route Number.	City or Town, State, Zip Code)
	Health Health tem 27 other tr		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Chy B	ACTION OR MO 2123(
Baltimore,	permit. Pages Department of Important: If i any injury or once.	Ì	· 4 Donation 5 Other (Specify) Arlington lational (1M. 12.	-8-05 t	telington, VA EIND 212321.
	<u>0</u> 05 % 0		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. Ust only one cause on each line.		SST, Approximate Interval Between Onset and Death
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. OMPLICATION OF HIP FR Due to (or as a consequence of):	ACTURE	3
	ted nsit	Examiner	Sequentially list conditions, large and the form of th	DOROVED BY MEDIC	CALEXAMINER
8760,	ate be executed hysician and the burial-transit	ical Exa	that initiated events resulting in death) Last Due to (or as a consequence of): CERTIFICATION AS		
Box 6	ath certific attending pl for use as t	Physician/Medi	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delivery Month Day Year
ls, P.0	ires that the de signed by the a be detached	þ	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		eacco use contribute to the cause of death?
Division of Vital Records,	e law requir has been si je 2 should	Completed	1.071 HIE CANCER	24a. Was ar autops	24b. Were autopsy findings available prior to completion of cause of
Vital F		Be	examiner?	1 ☐ Yes 2 h (Check only one	1 Yes 2 No
on of	Attending Physician: r death. ector: After this certification the funeral director.	tlon; To	27. Manner of Death 1 Dending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28c. Injury at Work?	28d. Describe ho	
Divisi	al or Attendi after death. I Director: A d in by the fu	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 1 Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town	reet and Number or Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dire completely filled in b.	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated.	and due to the ca	use(s) and manner as stated.
	To th within comp	Me	29b. Signature and title of certifier 29c. License number RES-000	29	9d. Date signed (Month, Day, Year) $9 - 29 - 05$
	10.4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAMID SADEGHIAN 5601 LOCH RAVEN BLVD. BALTIN	IORE : I	
0	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature OCT 2 5 2005		

			1 - For State Registrar	State of Ma	ryland /		artment of F		nd Me		giene leg. No.		35687
	Physici	an	1. Decedent's Name (First, Middle, La	ist)			20114			2. Date of Dea Month IOVEMBE	_	O O O O O O O O O O O O O O O O O O O	3. Time of Death
2.00	/Medic	al	ROSE 4a. Facility Name (If not institution, gir	ve street and number)		F	AHM 4b. City, Town, o	or Location of		IONEMBE		2005	5:30 A M
	Examin	er	BRIGHTWOOD NUR				40. Ony, 10mm, 0		HERVI	LLE	40.0	-	LTIMORE
Ī	Funeral Director		212-05-8805	Sex 7. Age	(In yrs. last t	Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	SEP 3	, Year)91	9. Bir	thplace (State or Foreign puntry) MD
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation						10d. Inside City Limits
	Mary 9-f eh	tor	MD BAL	TIMORE				OWII	NGS M	11LLS			1 □Yes 2 No
	or 28	Directo	10e. Street and Number				10f. Zip Code	044			10g. Citize	n of What Co	
	eath v	erai	4 BRIDLEWOOD C	OURT 12. Was Decedent Ev	er in II C	12.1	Man Dandont of L	211		ifu Van as No	14	Dago - Ame	USA erican Indian.
5-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Iteme 23a or 28e-f ehow ont, the Medical Exeminer must be notilified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		1	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 No	an, Mexican, Specify:	Puerto R	ican, etc.)		Black, Whit	
<u>ဂ</u>	72 ho	eted	15. Decedent's E (Specify only highest gr		16	(Give	dent's Usual Occup	during most	of working	7	16b. Kind	of Business	Industry
127	within ene. than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired KKEEPER	d)			NFW (CITY O	PTICAL CO.
ק ק		Be Co	17. Father's Name (First, Middle, Las.)		DOO	KIKELI LIK	18. Mother	r's Name (First, Middle,			. , , 2 0 0 0
Maryland	should be ind Mental marked c	To B	ABRAHAM			FRAI			RAH			·	UNKNOWN)
	12 P I		JACK BAUMEL /	NEPHEW	15		ng Address <i>(Street</i> RIDLEWOOD				-		
Baltimore,	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	Removal from State	cemet	tery, crer	sition (Name of natory or other plac		Da		20c. Loca	tion - City or	
<u>=</u>	C 9 2		4 ☐ Donation 5 ☐ Other (Special Signature of Euperal Service Lice	fy)	BETH 1		C ADATH I				CON		LK, MD
n n	permit Depart Import any In		Botalo!	Tun									., INC. , MD 21208
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that caused to one cause on each line				ng, such as o	cardiac or	respiratory ari	est,		Approximate Interval Between Onset and Death
•	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	aB Due to (or as a			ancer						
	Examiner		Sequentially list conditions, if any, leading to immediate	b									
1	uted d unsit	miner	Cause (Disease or injury	Due to (or as a	consequence	e of):							
Š,	be executed sicien end burial-transit	Examin	that initiated events resulting in death) Last	Due to (or as a	consequenc	e of):							
09/89	icate be ex physicien s the buria	dical		d				_					
ŏ	death certificate e attending phys id for use as the	an/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 Live birth 2		th 3□	Ectopic pregnancy	v			23	d. Date of de	,
р С	the dea / the ati ched fo	Physician/Med	in the past 12 months? 1 ☐ Yes 2 Shio 9 ☐ Unknown	4□Pregnant at ti 9□ Unknown			Other (specify)				10	Month	Day Year
λ, J	law requires that the de se been signed by the a 2 should be detached f	by Ph	Part II. Other significant conditions	contributing to death but	not resulting	in the u	nderlying cause giv	en in Part I.		23e. Did to	bacco use	contribute to	the cause of death?
cord	w require been si should t								-		es 2		obably 4 Onknown
Ä	9 2 9	Completed								24a. Was a autops perfor	med?	prior to death?	utopsy findings available completion of cause of
NIT A	ucien: Th certificete rector, pag	Be C	25. Was case referred to medical examiner?					26. Place	of Death (1 ☐ Yes Check only or	(1 🗌 Yes	2)X(No
5	Physicien: rthis certific ral director,	ဥ	1 Yes 2/SuNo	Hospital:			t 3 DOA Oth	4 CUNUIT		e 5 Resid			cify)
	fter fter	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year)	. Time of Injury	Wor	ryat rk? ∣Yes 2.∐N		d. Describe h	ow injury o	occurred	
DIVISION	in Direction	Certification:	3 Suicide 6 Could not to determined		y - At home, (Specify)	farm, str	eet, factory, office		28	If. Location (S City or Tow		Number or Ri	ural Route Number,
	Hospitel		29a. Certifier 1 Certifying P	hysician: To the best of miner: On the basis of e	my knowled	ge, death	n occurred at the til	me, date and	d place, an	d due to the o	ause(s) ar	nd manner as	s stated.
	thin 24	Medicai	one) 29b. Signature and title of certifier	and manner state	ed.		29c. Licens						h, Day, Year)
	To To Con		▶ Moderal		1				23				
	F		30. Name and address of person who	~	(Item 23a	(Type,	Print)	0.		0 01		WA 2	239
	Sta		North Ferrige (90) 31. Date filed (Month, Day Year)	32 Registrar	's Signature	pu of	rut isuid	me of	503	13 cuthu	nove!	70 21	C>/
	Registr	ar	NOV 0 4 20	105 Element	K	Con	des						

DHMH 17 Rev 1/2001

ORIGINAL

		•	For Stete Registrar	State of Ma	ryland		artment of H	ealth a		ental Hyg	iene	05	356	88
			Decedent's Name (First, Middle, Last)				,			2. Date of Deat	h	Voor	3. Time of	f Death
ı	Physicia /Medic		Ina				raines		(October	26,	2005	9:17	7 A M
	Examin		4a. Facility Name (If not institution, give s	street and number)			4b. City, Town, or					ounty of Death		
			Summit Park Nursi		(la ura la	at hirthday	Catons If Under 1 Year	ville		Data of Birth	Ва	altimo:		
	Funeral Director		5. Social Security Number 6. Sex 285-46-9182	/ Age	95	st birthday) Yrs.	Months Days	Hours	Min.	B. Date of Birth (Month, Day, Jan • 10	Year) 19	10 Oh:	place (State o intry) 10	or Foreign
	ס		Usual Residence of Decedent											
	arylar show	_	10a. State 10b. County		-	Town or Lo							10d. Inside C	ity Limits 2 \(\sum \) No
	the M.	Director	Maryland Baltimor 10e. Street and Number	e	Bal	Ltimor	e 10f. Zip Code			1	De Citize	n of What Cou		2010
	with tage or 2	Dir	3116 Jeffery Road				21244			''	U.S		iritiy :	
	ns 23	era		12. Was Decedent E	ver in U.S	i. 13. V	Vas Decedent of Hi f Yes, specify Cuba	spanic Orig	gin? (Speci	ify Yes or No-		Race - Amer		
9	after or Iter	by Funeral	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	0				, Puerto Ri	can, etc.)		Black, White		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or Items 23s or 28s-f show strip injury or other traumatic event, The Medical Examination and the notified at anone.	d by	3X Widowed 4 □ Divorced	Year or Dates:			1 ☐ Yes 21X No	Specify:			Sp	pecify: B	lack	
<u>5</u>	"netu	Completed	15. Decedent's Educ (Specify only highest grade			16a. Deced	dent's Usual Occupa kind of work done of DO NOT use retired	ation luring most	of working	,	16b. Kind	of Business/I	ndustry	
7	withir ene. than	duic	Elementary/Secondary (0-12)	College (1-4or 5+	+)		emaker	,			Own	Home		
5	illed Hyg other	Be C	17. Father's Name (First, Middle, Last)					18. Mother	r's Name (First, Middle, A				
lar	uld be Aenta irked tic ev	To B	Charles Neil					May	Rea	gan				
Maryland	and I		19a. Informant's Name/Relationship (Ty)		- 4		ng Address (Street a					own, State, Zi	p Code)	
2	and lealth m 27	1	David Parker (Gra	ndson)	30h Blo		Jeffery F	-	Balti Da			inn City as T		
Baltimore,	int of h		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R	emoval from State	i.		sition (Name of natory or other place					ion - City or T		
<u>=</u>	it. Pa intmer intent injury		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service License	20	Gree		Cemetery Name and Addres			2005 C				
Ba	permi Depar Impo any ir		5Tun 9 11	0-00-	00		517 Vine		rie	tropoli				
			23a. Part1. Enter the disease, or compli	citions that caused	the death.							TIĞTILL	Approximat Interval Bet	te
110	Physician		shock, or heart failure. List only or Immediate Cause (Final disease or condition	Lause on each line	solow	hon	Preumo.	nia					Onset and I	Death
	/Medical		resulting in death)	Due to (or as a	conseque		1100110	11					C	7
	Examiner		Sequentially list conditions,),										
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	conseque	ence of):								
٦	xecut and al-tran	Examiner	that initiated events resulting in death) Last	Due to (or as a	conseque	ence of):								
8760,	ate be executed hysician and the burial-transit	calE												
9	tificate ig phy as the													
Вох	death certifica e attending ph ed for use as th	an/N	23b. was decedent pregnant	3c. If yes, outcome of			Ectopic pregnancy				23d	Date of deliv		V
В	e dea the att	sicl	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	4 ☐ Pregnant at t 9 ☐ Unknown			Other (specify)					Month	Day *	Year
P. 0.	The law requires that the death ate has been signed by the atter bage 2 should be detached for u	by Physiclan/Med	Part II. Other significant conditions cor	stributing to death bu	t not resul	iting in the u	nderlying cause give	on in Part I.		23e. Did tob	acco use	contribute to	the cause of d	death?
ds,	uires tha signed I id be det	d by	Congestive Hear	+ failur	re	and a second	naony mg oacoo give			1 ☐ Ye			bably 4 🗀	
Records,	w requir been s should	Completed	Charic Paral	Insuffic	1000	1.1				24a. Was ar	2	4b. Were aut	posy findings	available
Re	he lav e has age 2	дшс	Coll still 104/1001	VIGU STIC	6	7				autops	red?	prior to co death?	ompletion of c	ause of
ta	en: T	0	25. Was case referred to medical					26. Place	of Death (1 ☐ Yes 2 Check only one	25-N o	1 🗆 Yes	2 X No	
<u> </u>	Physicien: rthis certific ral director,	To B	examiner? 1 Tes 275No	lospital: 1 Inpatien	nt 2□E	R/Outpatier	t 3 DOA	er: 4 X Nur	rsing Home	5 Reside	nce 6	Other (Speci	fy)	
0 0	ng Pł		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year)	28b. Time of Injury	28c. Injury Work	at ?	28	d. Describe ho	w injury o	ccurred		
Sio	Attending it death. ector: After by the fune	catl	2 Accident investigation 3 Suicide 6 Could not be	00- Dissertished	- At b			/es 2□N		6 Landing (Ca				
Division of Vital	or At after d Direct in by	Certification;	4 Homicide determined	28e. Place of Inju- building, etc.	ry - At nor . <i>(Specify)</i>	ne, tarm, str	eet, factory, office		28	f. Location (Str City or Town	eet and N , State)	umber or Hur	ai Houte Num	ber,
_	spitel		29a. Certifier 15 Certifying Phys	sician: To the best of	f my know	/ledge, deatl	occurred at the tim	e. date and	d place, an	d due to the ca	use(s) an	d manner as	stated.	
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	edical	(Check only 2 Medical Examination)	ner: On the basis of and manner stat	examinati	on and/or in	vestigation, in my op	pinion, deat	h occurred	at the time, da	te and pla	ace, and due l	to the cause(s	;)
	To th withir To th comp	Me	29b. Signature and title of certifier				29c. License	number	-	29	d. Date s	igned (Month,	Day, Year)	
1			Donnel Col	Ound			19417	187		0	ctilo	er 26	200	15
	2		30. Name and address of person who co	A			Print)	a. iLi	MATAM	MS	21	244		
			31. Date filed (Month, Day, Year)) 7/4(Ja 32. Registra	P CUL		DIV C	K1177/	nv)C			/		
	Sta Registr		NOV 0 4 2	49	, s signall	k A	handle a							

		4	For State		State	of Mary	yland /	-	rtment of H				giene	005	356	89
		1	Registrar 1. Decedent's Name	(First Middle	l ast)							2. Date of Dea		000	3. Time of	Death
	Physicia	ın	P-FRE	71 DI	NE	1.	GR	A	HAM			Month	28 ^{Day}	2005	10:1	OPM
3	/Medic Examin	_	4a. Facility Name (If	not institution,	give street and r	number)			4b. City, Town, o	r Location o	of Death		4c.	County of Death	1	
90			St. Eliza	abeth l	Nursing				Baltin					n/a		
0,10	Funeral Director		5. Social Security Nu. 215–10–91.		6. Sex 1 ☐ M 2 🖾 F		n yrs. last b	irthday) Yrs.	If Under 1 Year Months Days	Hours	Min.	B. Date of Birt (Month, Da July 25	y, Year)	918 Mary	place (State o untry) 1and	r Foreign
-	2 .		Usual Residence of I	Decedent 10b. County		10	Oc. City, Tov	wn or Lo	cation						10d. Inside Ci	ty Limits
THE STATE OF	Maryland -f show ling at	5													MXYes	2 🗆 No
2	the Maryla 28a-f sho	ect	MD 10e. Street and Num	Queen	Anne		Stever	isvi.	10f. Zip Code				10g. Citi	zen of What Co	untry?	
()	23a or	Funeral Director	805 01d	Love	Point Rd				21666				1	USA		
7	death ms 2	nerg	11. Marital Status		12. Was De	ecedent Eve Forces?	er in U.S.	13.	Vas Decedent of H	lispanic Ori an. Mexical	igin? (Spec	ify Yes or No ican, etc.)	-	14. Race - Ame Black, White		
RALDINE 036	within 72 hours after death with the ane. anenatural, or items 23a or 28a than "hatural", or items 23a or 28a than Madical Examiner must be multi-		1 Never Marrie		ed 1 TYe	s 2 No Give			☐ Yes 2€ No						nite	
215-0036	72 hours natural', ncal Ex	ed by	3 Widowed	15. Decedent		Dates:	16	a. Deced	lent's Usual Occup	ation			16b. Ki	nd of Business/	ndustry	
5 5	in 72 n nai	Completed	(Special	fy only highes	t grade complete	d) (1-4or 5+)		(Give	kind of work done OO NOT use retire	durina mos	t of working	g			ŕ	
25	d with giene	mo	Elementary/Secon	_	College	(1-401 3+)	Win	re T	ech.			-	Wes	tinghous	se	
_ P	be filed withing that Hygiene. Ind other than event, the M	Be C	17. Father's Name ((First, Middle,	Maiden	Sumame)		
y ya	Menid to Men	70	Oscar G				10	No. Mailia	ng Address (Street		a Car		ar City o	r Tour State 7	in Code)	
HATM Maryland	d 2 sh h and 7 is rr treum		19a. Informant's Na													
(c)	s 1 and 2 should be filed within if Health and Mental Hygiene. item 27 is marked other than other treumatic event, the Mental Health in		Robert 20a. Method of Disp	osition			20b. Place	of Dispo	1d Love I	1		Sceven	20c. Lo	cation - City or	Town, State	
No in	ages ant of at: If it		ty Burial 2 ☐ 4 ☐ Donation	☐Cremation 5 ☐ Other (Si	3 □Removal fro	m State			natory`or other pla rk Cemete	1	ov. 1	, 05	Balt	imore C	ity	
0 7 #	Demit. Page Department of Important: If any injury or once.		21. Signature of Fur			>		22	. Name and Addre	ss of Facil	ty Lou	don Pa				
W W	Departing any i		-					3	620 Wilke	ens A	ve. B	altimo:	re,	Marylan	1 21229)
	Physician /Medical Examiner	ner	23a. Part1. Enter If shook, or hear Immediate Cause (disease or condition resulting in death) Sequentially list corif any, leading to imcause. Enter Under Cause (Disease or Cause (Disease (Di	rtfailure. List Final n	aDue	to (or as a c	consequence	eh : 01):	ral Va	X J C C	1	/ CU		'dent	Approximal Interval Bet Onset and 4 M	ween
	tificate be executed g physicien and as the burial-transit	dical Examiner	Cause (Disease or that initiated events resulting in death) L		c Due	to (or as a	consequenc	e of):								
P.O. Box 68	Physician: The law requires that the death certifica this certificate has been signed by the attending phrail director, page 2 should be detached for use as it.	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12, 1 Yes 2 in 12 yes 2 i	months? XNo	1⊡Liv 4⊡Pr		pregnancy □ Fetal dea ne of death]Ectopic pregnanc] Other (specify) _	:у				23d. Date of del Month	•	Year
ds, P	w requires that been signed I should be det	þ	Part II. Other signif	icant condition	ons contributing t	o death but	not resulting	g in the u	nderlying cause gr	ven in Part	1.	1		use contribute to ☐ No 3 ☐ Pr	10	death? Unknown
Division of Vital Records,	ysician: The law requiscertificate has been director, page 2 should	Completed	17/	erli	sidei	NIO						24a. Was auto perfe		prior to	itopsy findings completion of a	available cause of
ita	ician: Th certificate ector, pag	Be	25. Was case refer examiner?	red to medica								(Check only				
of V	Physic this co	2	1 □ Yes 3			Inpatient		Outpatie	nt 3LI DOA			ne 5 Res		6 □Other (Spe	cify)	
ou c	ding Ph h. After th funeral	lon	27. Manner of Deat 1 Natural	n 5 □ Pendir investi	9	ate of Injury Month, Day	Year)	Injury	Wo	ork? ∃Yes 2.⊑		od. Describe	now inju	ry occurred		
Divisio	or Attendent frer death prector; n by the	Certification;	2 Accident 3 Suicide 4 Homicide	6 Could determ	not be 28e. P	lace of Injury uilding, etc.	y - At home, (Specify)	, farm, st	reet, factory, office			28f. Location City or To	(Street ar	nd Number or Ri e)	ural Route Nur	nber,
	To the Hospitel of within 24 hours a To the Funerel Completely filled it	edical C	29a. Certifier (Check only one)	1 Certifyii 2 Medical	Examiner: On th	the best of le basis of e nanner state	xamination	dge, dear and/or in	th occurred at the to	ime, date a opinion, de	and place, a	and due to the	cause(s , date an) and manner as d place, and due	s stated. to the cause(s)
	within To th compl	Me	29b. Signature and	I title of certifie					29c. Licen	ise number	20		29d. Da	ate signed (Mont	h, Day, Year)	1
	(M	Im	0	P	55	57	1 ()cto	ober 3	1,20	105
	- V		30. Name and addr	ress of person	who completed	Sen	ath (Item 23.	а) (Туре	, Print) V-lM W	e, E	Balt	n'm "	e,	Mary	and.	[5515
	St Regist	ate	31. Date filed Mon	NOW Year	# 2005 3	2. Redistrar	's Signature	-	hine i					/		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienel 05Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Nelford Goodman, Junior 1:12PM October 31 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bayview Medical Center Johns Hopkins Baltimore tf Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year)
Aug. 24, 1931 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 M 2□ F 74 Virginia Director 231–36–3671 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Dunda1k 1 Yes 2 No Baltimore Maryland Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13 Sollers Point Road 21222 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ X lo Specify: Specify: White by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) 12 Steel Worker Stee1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Nelford Ray Goodman, Sr. Fannie Hatchett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Hatcher, Sister 2205 Oakwood Lane, Richmond, Virginia 23228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Depertment of H.
Important: If Iter
any injury or oth 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Altavista Memorial Park 11/03/05 ' 4 ☐ Donation 5 ☐/Other (Specify) Altavista, Virginia 21. Signature of Fuca 22. Name and Address of Facility Finch & Finch, Inc. Ma P.O. Box 85, Altavista, Virginia 24517 MO1113 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Respiratory hronic 4 hours Pulmonary Disease Chronic Obstructive
Due to (or as a consequence of): Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Klebsiella pneumonia, hypertension, 1 Nes 2 No 3 Probably 4 Unknown chronic disease, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe vascular disease peripheral 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ۲

Physician /Medical **Examiner**

death with the Maryland

Baltimore, Maryland 21215-0036

Item 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at

Hygiene.

Pages 1 and 2 should be fill nent of Heelth and Mental Hy nt: If Item 27 Is marked oth ry or other traumatic event

attending physician and for use as the burial-transit ed by the a ed bluods the funeral director, after death.

Division of Vital Records, P.O. Box 68760,

To the Hospitel or Attending Physicien:

28a. Date of Injury (Month, Day Year) 5 Pending investigation

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mb

6 Could not be

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

 Place of Initury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

md 21224

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

4940 Eastern Avenue Baltimore

29d. Date signed (Month, Day, Year)

October 31 2005

Mark Liu 31. Date filed (Month, Day, Year) State

27. Manner of Death 1 ☑Natural

2 Accident

3 Suicide

29a. Certifier

Certification:

Medical

32. Registrar's Signature

NOV 0 4 2005



DHMH 17 Rev 1/2001

Registrar

within 24 hours a

To the Funerel D

completely filled i

			State of Maryla For State Registrar	nd / Depa	artment of H	ealth and N	Mental Hyg	jiene	
	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last) The Sulth Her				2. Date of Dea Month		Tiple Death - 06 45A M
	Examin Funeral Director	ér	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center 5. Social Security Number 220-20-1157 6. Sex 1 M 2K F	s. last birthday) 9 Yrs.	Annap	Olis If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day May 16,	Anne Arus 9. B (Year) West	
	the Maryland 28a-f show	rector	Usual Residence of Decedent 10a. State 10b. County 10c. C Maryland Baltimore 10e. Street and Number	Catons				log. Citizen of What (10d. Inside City Limits 1 ☐ Yes 2XINo
36	tiled within 72 hours after death with the Maryland Hygiene. Ather than "natural", or items 23a or 28a-f show ant, Ite Medical Examinat must be notified at	by Funeral Director	1432 Gibsonwood Road 11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in Armed Forces? 1 Yes ZiXNo If Yes, Give		21 Was Decedent of Hi If Yes, specify Cuba 1□ Yes 2\\$\frac{1}{2}\$No	228 spanic Origin? (Sin, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	U.S.A 14. Race - An Black, Wh Specify:	nencan Indian, lite, etc.
21215-0036	filed within 72 hours Hygiene. other than "natural! ent, the Medical Es	Completed b	3⊠ Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation luring most of wor.)	king	16b. Kind of Busines Own Ho	·
Maryland	should be nd Mental marked c	To Be C	17. Father's Name (First, Middle, Last) Glen Ireland 19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street a	Blanch	e Post	Maiden Sumame) r, City or Town, State,	Zip Code)
Baltimore, Ma	and 2 lealth a m 27 is		Laburial 2 Cremation 3 Linemoval from State	Place of Dispo cemetery, crea	ickett Co	θ)		20c. Location - City of	or Town, State
Baltir	permit. Pages 1 Department of H Important: if ite any injury or ot once.		21. Signature of Funeral Service Licenses	Wind Win	630 Edmon	s of Facility Pral Home dson Ave	of Cato	onsville, ille, Mary	land 21228
	Physician /Medical		23a. Part1. Enter the disease, or nonclications that caused the de shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	e i a	ter the mode of dying	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death Milmtes
3760,	ate be executed any sician and he burial-transit	licai Examiner	Sequentially list conditions b. Apple	equence of):	olle				days
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
	w requires that been signed to should be deta	by	Part II. Other significant conditions contributing to death but not re Parkynsons and Jean. Dementin		inderlying cause give	en in Part I.	23e. Did to		to the cause of death? Probably 4 □Unknown
of Vital Records,	iician: The law r certificate has be rector, page 2 sh	Completed					24a. Was a autops perior 1 Yes	sy prior to	
	Attending Physician: Th death. ctor: After this certificate y the funeral director, pag	ation: To Be	25. Was case referred to medical examiner? Yes 2 No	ER/Outpatier 28b. Time of Injury	of 28c. Injury Wark	er: 4 🗆 Nursing H		ne) ence 6 □Other (Sp ow injury occurred	ecify)
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	i Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At building, etc. (Spe	cify)			City or Tow		
	To the Hosp within 24 ho Fo the Fune completely fi	Medicai	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my k 2 Medicel Exeminer: On the basis of examinand manner stated. 29b. Signatura and title of certifier		29c. License	oinion, death occu o number	rred at the time, d		ue to the cause(s)
	61		30. Name and address of person who completed cause of death (It	1441	Print) AA	2242 MC		11/3/0	
	Sta Registi		31. Date filed (Month, Day, Year) NOV 0 4 2005	Pature Span	all I				

		•	For State Registrar	State of M	Maryland		artment of H				giene	005	35692
			Decedent's Name (First, Middle)	, Last)						2. Date of Dea	ath	Year	3. Time of Death
,	Physici: /Medic		DANIEL	М			HYMAN			NOVEMBE		2005	9:20 A M
)	Examin	er	4a. Facility Name (If not institution 10101 GROSVENO)	-		20	4b. City, Town, or ROCKVIL		of Death			OUNTY OF DEATH	
	Funeral		5. Social Security Number	6. Sex 7. A	. #102 Age (In yrs. la		If Under 1 Year	If Under	24 Hrs.	8. Date of Birt			pplace (State or Foreign
	Director		218-36-6758	1 M 2 □ F	65	Yrs.	Months Days	Hours	Min.	8. Date of Birt (Month, Da APR. 8,	940	Col	MD
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ocation						10d. Inside City Limits
	Marylan Iied at	to	MD MO	NTGOMERY		ROC	KVILLE						1 ☐ Yes 2 ☐ No
	or 28e	Funeral Director	10e. Street and Number			- 1100	10f. Zip Code				10g. Citize	n of What Co	untry?
	ath wi	rai	10101 GROSVENO					2085					USA
	item item	-une	11. Marital Status 1 X Never Married 2 ☐ Marr	12, Was Deceder Armed Forces ied 1 ☐ Yes 2 🔀	\$?		Was Decedent of Hi If Yes, specify Cuba	n, Mexican	gin? (Spec n, Puerto P	offy Yes or No- lican, etc.)	. 14	. Race - Ame Black, White	e, etc.
036	rei', or	6	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	•		1 ☐ Yes 2 🗖 No	Specify:			Sį	pecify:	WHITE
Maryland 21215-0036	within 72 hours after death with the Maryland one. Itan "naturel", or iteme 23a or 28e-f ehow he Maulical Examiner must be notified at	Completed	15. Deceden (Specify only highes	's Education st grade completed)		(Give	dent's Usual Occupa kind of work done	turing most	t of workin	g	16b. Kind	of Business/I	ndustry
12	within ene. than	duic	Elementary/Secondary (0-12)	College (1-4o	r 5+)		DO NOT use retired PUTER SCI		ξT.		COME	PUTERS	
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ylar	2 should be filed within and Mental Hygiene. Is marked other than eumatic event, the Mental and	To B	HENRY			НҮМ	AN	ES	STELL	Ε			DATKYN
Mar	12 sho		19a, Informant's Name/Relations				ng Address (Street a				-		
	1 and Heelth Iem 27 other tr		ESTELLE HYMA 20a. Method of Disposition	N / MUTHER	20b. PI	ace of Dispo	sition (Name of	I		• #ZZU		tion - City or	, MD 21215 Town, State
altimore,	Pages nent of int: If it		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		8	•	matory or other plac AEL CEMET		1/03	/2005	B/	ALTIMOR	RE. MD
a	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Maralla Hygiens. Department of Health and Maralla Hygiens. Instruction: If item 27 is marked other than "naturely, or items 23s or 28s-1 ehrovery injury or other treumatic event, Ite Maralla Examinar must be notified at ance.		21. Signature of Funeral Service		- Di	T	2. Name and Addres			L LEVIN			
8	80 E 9 9		15000	V					LOMN	ROAD -	PIKES		MD 21208
			23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	only one cause on each	line.				cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
j.	Physician /Medical	i.	disease or condition resulting in death)	a. Due to (A)	UZON	lence of):	inford	w					Menute
	Examiner		Consensation lies are distance	, 18m	enter	m							Year
	sit sq	iner	S quentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to () a	is a consequ	ence of):							
12	xecute and	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a	is a consequ	ience of):						_	1
760,	ate be executed hysicien and the burial-transit	caiE		d									
9	w requires thet the death certificate been signed by the attending phys should be detached for use as the		IF FEMALE:	1			A. 1 4 7 (M. A.)						
Division of Vital Records, P.O. Box	Physicien: The law requires thet the death certifics this certificate has been signed by the attending phair director, page 2 should be detached for use as the	by Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant	2 Fetal	death 3	Ectopic pregnancy Other (specify)				230	d. Date of delifination	very Day Year
o.	the de	nysic	1	9 Unknown		Jaill 5							
o. O.	ss thet gned b	by PI	Part II. Other significant condition	ons contributing to death	but not resu	Ilting in the u	nderlying cause give	en in Part I.		23e. Did to	obacco use	contribute to	the cause of death?
ord	een si		Byperia	Silver	-					101	res 2)	No 3∏Pro	obably 4 Unknown
3ec	has b	Completed								24a. Was autop		24b. Were au prior to d death?	topsy findings available ompletion of cause of
<u>a</u>	ificete or, pag	e Co	25. Was case referred to medical	_				OC Disease	of Dooth	1 ☐ Yes (Check only o	2 No		2□ No
<u> </u>	ıysicie iis ceri direct	To B	examiner? 1 🗆 Yes 2 🗷 No	Hospital: 1 ☐ Inpa	tient 2 🗆 I	ER/Outpatier	nt 3 DOA Othe			e 5 Resid		Other (Spec	city)
0	ding Physicien: The lav h. After this certificete has funeral director, page 2	:uo	27. Manner of Death 1 ☑Natural 5 ☐ Pendin	28a. Date of In (Month, D	njury Day Year)	28b. Time o Injury	Work	at c?	2	8d. Describe h			
isio	Attending or death. ector: After by the fune.	icati	2. Accident investig 3 ☐ Suicide 6 ☐ Could	not be 280 Place of I	laiuar - At ha	mo farm ch	M 1 □ 1 □ 1	Yes 2 🔲		9f Location /9	Stroot and f	Number of Bu	ral Route Number,
<u>≥</u>	al or A sefter i Direct d in by	Certification;	4 Homicide determ	building,	etc. (Specify)	eet, factory, office			City or Tox		vanibar or ria	iai noute vainoei,
	To the Hospitel or Attend within 24 hours efter death To the Funerel Director: completely filled in by the 1	edicai C	29a. Certifier 1 Certifyin (Check only 2 Medical	g Physician: To the bes Examiner: On the basis	st of my know	wledge, deat	h occurred at the tim	ne, date an	id place, a	nd due to the	cause(s) ar	nd manner as	stated.
	thin 24 the F mplete	Medi	one) 29b. Signature and title of certifie	and manner	stated.		29c. License					signed (Month	
	7 ¥ 7 8		Duran		0			639	4			ios	, = wy, roat/
	V		30. Name and address of person	who campleted cause of	f death (Item	23а) (Туре,	Print)					110	
	10		DONALD T.	MEGLEI	1 6	569	W, CHAR	LES	ST	#411	,,,	MD	21204
	Sta Registr		31. Date filed (Month, Day, Year)	.40	strar's Signat								
	* 3		1107 0 12 2	UU) Ma	14	-	A.						

			State of					Mental Hygid	_	e.
		1 - For State Registrar	Olaic Ol	i wai yiana		rtificate of I			0 0 S	5 35694
		1. Decedent's Name (First, Middle						2. Date of Death Month		3. Time of Death
Physic /Med			JOSEPH	KREBNEF	₹			NOVEMBE		05 1:00A M
Exam	iner	4a. Facility Name (If not institution,					Location of Death		4c. County of I	Death
Funera		RIVERVIEW NURS 5. Social Security Number		7. Age (In yrs. las	st birthday)		SSEX If Under 24 Hrs.	8. Date of Birth		ALTIMORE Birthplace (State or Foreign
Directo		215-16-0983	1 X M 2□F		32 Yrs.	Months Days	Hours Min.	(Month, Day, Y		Birthplace (State or Foreign Country) MARYLAND
and		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Lo	cation				10d. Inside City Limits
(36) Its after death with the Maryland I, or items 23s or 28s-f show	ţō	MD	N/A			CLI	FTON			1)X Yes 2 □ No
th the or 28s	Director	10e. Street and Number				10f. Zip Code		109	. Citizen of Wha	it Country?
ath wi	ra	3313 LAWNVIEW					21213		U	J.S.A.
ie ie	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marri	Armed For		13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.
	þ	3 X Widowed 4 □ Divorced	If Yes. Give	entes: WWII		1⊡Yes 2∭XNo	Specify:		Specify:	WHITE
	Completed	15. Decedent' (Specify only highest	s Education t grade completed)		(Give	dent's Usual Occupa	lurina most of worl	king 16	b. Kind of Busin	ess/Industry
	l m	Elementary/Secondary (0-12)	College (1-	-4or 5+)		DO NOT use retired ACHINE OP			₩₽₽Ͳ₽₩	ELECTRIC
Ind 212 be filed with tal Hygiene. d other then event, It e M	a)	17. Father's Name (First, Middle, L	_ast)					e (First, Middle, Ma		LUCTRIC
	To B	JERRY	KREBNER				ANNA		(UNKNO	WN)
C 6 - 0		19a. Informant's Name/Relationsh CHARLES KREBNER						ral Route Number, C		
s 1 and f Health item 27 other tr		20a. Method of Disposition	./ DOM	20b. Plac		WILHELM A		ROSEDALE,		11237 y or Town, State
ဥာ ခွာႏွ≒ ခ		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		Statecerr	netery, crer	natory or other place NATIONAL	θ)			E, MARYLAND
Baltin permit. Pa Departmer Importent any injury		21. Signature of Funeral Service L) .				CH/ROSEDA	LE FUNE	RAL HOME
D 89889			~ ()		-	211 CHESA			ALE, MD	21237
		23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final	omplications that ca only one cause on a	used the death. ich line.	Do not ent			1		Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. Due to /	or as a consequer	200.00		eman	na.		Cur-Know
Examiner		Constitution and disconn	b 000 10 (c	n as a conseque	100 01).					
J pg is	lner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury	Due to (o	or as a consequer	nce of):					
xecute and	Examiner	that initiated events resulting in death) Last	c. Due to (c	or as a consequer	nce of):			_		
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ortificating physics as the		IF FEMALE:		Ti Ti Li Li	20.					I.
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the de	Physician/Med	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknov	int at time of deat wn	in 5∟	Other (specify)				
s that	by PI	Part II. Other significant condition			ng in the ur	iderlying cause give	AA 1		co use contribut	e to the cause of death?
law requires (as been signed)	ted	Prosove	- Con	-cer	w	the osa	ne Mela	u, 1 ☐ Yes	2 □ No 3 □	Probably 4 Unknown
e law has b	ompleted	CAD,	-					24a. Was an autopsy	24b. Were prior	autopsy findings available to completion of cause of
VII.dir icien: Th sertificate ector, pag	e Col	25. Was case referred to medical						performed 1 ☐ Yes 2 ☐	r/ deatr	n? Yes 2□No
ysicie is cert directi	0	examiner?	Hospital: 1 🗆 In	patient 2□ER	VOutpatien	0the	-	n <i>(Check only one)</i> me 5 ☐ Residenc	a 6 □Other (S	Specify)
ng Phy filer this	on: T	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of (Month	Injury 28 Day Year)	Bb. Time of Injury	28c. Injury Work	at	28d. Describe how		posity
Attending r death.	icatl	2 Accident investigation investigation Accident investigation investigat	ation	of letters. At he are			es 2 □No	201.1 - 11 (0)		
after after d in by	Certification:	4 ☐ Homicide determin	ed 288. Place of building	of Injury - At home g, etc. <i>(Specify)</i>	a, rarm, stre	et, factory, office		City or Town, S	t and Number or tate)	r Rural Route Number,
To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	edical C	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the b xaminer: On the bas	pest of my knowle	edge, death	occurred at the time	e, date and place,	and due to the caus	e(s) and manner	as stated.
the H hin 24 the F	Medi	Une)	and manne	er stated.	and/or inv					
5 ¥ € S		29b. Signature and title of certifier	N-0			29c. License	-38-7	54 L	Date signed (Mo) -64	onth, Day, Year)
^		30. Name and address of person w	no completed cause	of death (Item 23	Ba) (Type, F	Print)	7		1 4 5	
10		MALIKA WI	ASCEM	70	9. E	ASTER	IN 15L	VD - 1	VID - 2	2005 21221
St Regist	ate rar	31. Date filed (Month, Day, Year)	2005 32. P	istrar's Signature	4	local)				
ricgist	TEIF			×	_7					

			For State Registrar Amend Item	State of I	Maryland I,25,	1 / Depa 27,28	rtment	of He	ealth a	nd Me	ntal Hy 29/06 0	giene	000	- ,	7 pm et e	E Fried
	No.		Decedent's Name (First, Middle, La.								2. Date of De	ath	000	,	3. Time of Data	atto
	Physicia /Medic		Roy Cecil Kelley								Month Octobe	r 29	, 200 <u>°</u>		1:38 H	РМ
	Examin		4a. Facility Name (If not institution, give	street and numb	er)		4b. City, T	Town, or	Location o	f Death		4c.	County of D	eath		
42	A		Washington Advent				Takon If Under		ark If Under 2	A Hre	. D				County	
	Funeral Director		5. Social Security Number 6. S 1 232-54-4312	M 2□F	Age (In yrs. la		Months	Days	Hours	Min.	3. Date of Bir (Month, Da	y, Year)		Country	ce (State or Fo v) Virgin	
	4	-	Usuat Residence of Decedent								Thiri	10,	1930 .		VIIGII	IIIa
	nrylan show	_	10a. State 10b. County		10c. City	, Town or Lo	cation							100	d. Inside City Li	
	the Marylan 28a-f ahow	Director	Maryland Montgome	ry	Gait	hersb						40 000	f 140		1 ☐ Yes 2 ₹	Ž IVO
	€ 9 €	O.	10e. Street and Number				10f. Zip					-	zen of What		y r	
	na 23a	Funerai	7645 Laytonia Dri	12. Was Decede	ent Ever in U.S	6. 13.	Vas Deced	877 ent of His	panic Orig	in? (Spec	ify Yes or No		ed Sta 14. Race - A	Americar		
1 9	or Iter		1 Never Married Married	Armed Force	No	-	Yes, speci □ Yes 2			, Puerto H	ican, etc.)		Black, V	Vhite, et	C.	
5-0036	ours a	d by	3 Widowed 4 Divorced	If Yes, Give Year or Date	s:		Tes 2	2 □ NO	<i>Specify:</i>				Specify:	Whi	<u> </u>	
		Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)		(Give	lent's Usual kind of wor DO NOT us	k done di	uring most	of working	7	16b. Ki	nd of Busine	ess/Indu	stry	
2121	d within giene.	duc	Elementary/Secondary (0-12)	College (1-4	or 5+)		racti	,				Se1	E-Empl	love	đ	
	Hyg Hyg Int,	BeC	17. Father's Name (First, Middle, Last,			00110	14001		18. Mothe	r's Name	First, Middle			LOYC	<u>u</u>	
la l	Q 20 D		Alvy Cecil Kelley						Hetti	e S.	Shoem	aker				
Maryland	01 03 00 00		19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	g Address	(Street a	nd Numbe	r or Rural	Route Numb	er, City o	Town, Stai	te, Zip C	code)	70
	1 and 2 Health tem 27		Lilias Susan Kell	ey/Wife	20h Pl	7645 ace of Dispo			Dr.,	Gait!	nersbu		ID 208 cation - City		- State	
Baltimore,			20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐		ate Ce	metery, crer	natory or ot	her place								
			4 Donation 5 Other (Specification 21. Signature of Funeral Service Licer		#CCC	100 PM 4					2005		gitsvi	ille	, WV	_
Ba	permit. Departr Import		1 langet	Busa	1	S	haffe 30 Fa	r-Wa	rnick	Fund	eral He Romney	ome	26757	7		
-	- Constant		23a. Part1. Enter the disease, or com shock, or head failure. List only	plications that cau	sed the death								20131	-	Approximate nterval Between	an.
	Physician		Immediate Cause (Final disease or condition	1. 0.00	Com	oricat	ions	OI S	urgic	al w	ound r	epai	r	Ö	onset and Deat	ith *
	/Medical		resulting in death)		as a consequ	ence of)	•				/	7			1010	TIPL
100	Examiner	L	Sequentially list conditions,	b		onary	arter	у ру	pass	surg	ery					
ı.l.	ted nsit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D00 10 (01	as a consequ	ence or).					[[[]	7				
19-	be executed sicien and burial-transit	xar	that initiated events resulting in death) Last	c. Due to (or	as a consequ	ence of):				-	Mu	N	·····IED			
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9	certifical nding phy use as th	Aedi	IE ESMAI S						CERT	MFICATION	Fu ·					
Box	aath cer attendin for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		n 2 🗆 Fetal	death 3	Ectopic pre					2	3d. Date of Month		ay Year	ır
	the a	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnan 9 ☐ Unknow	it at time of de n	ath 5□	Other (spe	ecrfy)					10101111		uy	
P.0	Attending Physician: The law requires that the death certificate or death. octor: After this certificate has been signed by the attending phys. by the funeral director, page 2 should be detached for use as the		Part II. Other significant conditions	ontributing to deat	th but not resu	lting in the u	nderlying ca	use give	n in Part I.		23e. Did t	lobacco u	se contribut	e to the	cause of death	th?
Vital Records,	quires n sign	d by	Chronic Obs	tructiv	e Pu	/mo	uar	1d	15 e	use	10	Yes 2	□No 3□] Probab	oly 4 Dunkr	nown
Ö	aw requir as been si 2 should I	piete	Coronary A	rteru	DIS	2015	0 1				24a. Was		24b. Were	e autops	y findings avai	ulabte
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ita	iclan: The certificate harector, page	Вес	25. Was case referred to medical examiner?	7/ 00		~/ /0/	CIEIC	7.0		of Death	Check only					
of V	Physic this co	မ	Yes 2 No	Hospital: 1 Inp		ER/Outpatier			4 140		e 5 ☐ Resi			Specify)		
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Division	death death ctor: /	licat	2 Accident investigatio 3 Suicide 6 Could not be determined	10/29		Unkno			03 2 201		COTODO	7717 O	roft /	duri	ng Bulle Number,	· ·
Ö	after after Dire	erti	4 Homicide		Injury - At ho , etc. (Specify Spital)	,						Adven	tist	Hospi	tal
	To the Hospitel or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	sai C	29a. Certifier (Check only 2 Medical Example ysician: To the be	est of my know	vledge, deat	occurred a	at the tim	e, date and	d place, ar	600 Ca	cause(s)	and manne	r as stat	koma P	ark	
	the H nin 24 the Fi	ledicai	one)	and manne	r stated.	ion and/or in				in occurre	at the time,					
	with To	Σ	29b. Signature and title of certifier	1				License		~		29d. Dat	e signed (M	Ionth, Di	ay, Year)	
	in		JXX M	Kes, 1	100	22-) (T			768			10	164/	20.		
	η		30. Name and address of person who	M. D. デ	or death (Item 454 1/	23a) (Type,	AVI	5 H	ノフェ	75	MILL	NA	HAK	I	MD Z	ncie
	- 3 % C+	ite	31. Date filed (Month, Day, Year)	05 Reg	gistrar's Signat	ure	~ V C	1. 11	101	1	C1101	10	1113	4	1-10 20	20/3
	310			111) 1000			- A E/									

DHMH 17 Rev 1/2001

Registrar

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2005

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05-7368 B.K.S PATRICIA KING

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

RIC	IA KING	j	_ For	State of N	Marylan	d / Depa	artment o	f Healt	h and N	Mental Hy	giene			
		•	1 - State Registrar			Cei	rtificate (of Dea	th		Reg. Ne)5	356	97
*	Physicia	an	Decedent's Name (First, Middle, Last	st)	T/ i no		_			2. Date of De Month	ath Day	Year	3. Time of	Death
E	/Medic		Patricia		King		1 0 T		(5)	NOV.	1, 200		1131	Ам
-	Examin	er 	4a. Facility Name (If not institution, give JOHNS HOPKINS BAY	VIEW MED	ICAL C			LIMORI	E CITY		4c. County	of Death		
	Funeral		5. Social Security Number 6. S	ex 7 □M 2【XF		last birthday)	If Under 1 Y Months Da	ear If Un ays Hou	der 24 Hrs. rs Min.	8. Date of Bin (Month, Da	18,1949	9. Birth Cou 177	place (State ontry)	r Foreign
1	Director		214-50-3782 Usual Residence of Decedent		5	66 Yrs.				March	10, 1949	VE	1.	
	nylane how		10a. State 10b. County		10c. Cit	y, Town or Lo							10d. Inside C	´
	8a-f	ecto	MD Baltimo	re		Dunda							1 ☐ Yes	2 (No
	with t a or 2 Lbs n	Funeral Director	10e. Street and Number 1 parkwood Road				10f. Zip Co	21222			10g. Citizen of \	What Cou SA	intry?	
	death ms 23	era	11. Marital Status	12. Was Decede	nt Ever in U	.S. 13.			Origin? (Sp	pecify Yes or No Rican, etc.)		e - Ameri	can Indian,	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Heelih and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28a-f ehow or other traumatic event, the Madical Examinar must be notified at		1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Force 1 Yes 2 If Yes, Give Year or Date	∑ No	i	If Yes, specify 1 ☐ Yes 2X			Rican, etc.)		ck, White, v: Whi		
5-0036	2 hou	Completed by	15. Decedent's Ed	lucation		16a. Dece	dent's Usual O	ccupation			16b. Kind of B	usiness/lr	ndustry	
215	within 7; ene. then "n	pie	(Specify only highest gra	de completed) College (1-4d	or 5+)	(Give	kind of work d DO NOT use re	one during (atired)	nost of work	king				
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Maryland	2 should be filed withir and Mental Hygiene. Is marked other then aumatic event, the Me	To Be	17. Father's Name (First, Middle, Last) Elmo Clark							e (First, Middle, : Quesen	Maiden Suman berry	10)		
lary	2 should and Men is marke	-	19a. Informant's Name/Relationship (reet and Nu	mber or Rui	ral Route Numbe	er, City or Town,	State, Zi	p Code)	- 6
	s 1 and 1 Heekth Item 27 other tr		Daniel Rodgers 20a. Method of Disposition	Husban	20b. F	Place of Dispo	sition (Name o	of		lalk,MD. miber	20c. Location	City or T	own, State	
Baltimore,	Pages ment of ant: If if ury or c		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from Sta	(0	-	matory or other L1 Memo		4, 2		Middle 1	Rive	, MD.	
Balt	permit. Page Department of important: if any injury or once.		21. Signature of Funeral Service Licer	onne	lly	23	Name and A Connell 7110 So	y Fund 11ers	eral F Point	Iome Of Road,	Dundalk Dundalk	,P.A.	21222	
100	#y 250 M - 250		23a. Part1. Enter the disease or com shock, or heart failure. List only	plications that caus	sed the deut	h. Do not ent	ter the mode of	dying, such	as cardiac	or respiratory a	rrest,		Approximat Interval Bet	e ween
	Physician		Immediate Cause (Final disease or condition	a Hyperi	Ensive	= Athe	1656 600	hic CA	Willy.	scubr T)i Lease		Onset and	Death
	/Medical Examiner		resulting in death)		as a conseq				-					
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8760,	physicate t	dica		d								-		
Box 6	death certifica ettending ph d for use as th	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor			-				23d. Da	te of deliv	erv	
.O. B	The law requires that the death certificate be executed to has been signed by the ettending physicien and tage 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1□Live birth 4□Pregnan 9□Unknowr	t at time of d		⊒Ectopic pregr ⊒ Other (s <i>pecit</i>				Mo	enth	Day	/ear
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of Vital Records,	law re las be	Completed								24a. Was	an 24b.	Were auto	opsy findings ompletion of c	available ause of
<u>~</u>	10	Cou									rmed?	death? 1 🗌 Yes	No	
Vite	Physician: r this certific ral director.	Be	25. Was case referred to medical examiner?	Hospital:	¥	ER/Outpatier		0.0		th (Check only o				
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ion	Attending I r death. ector: After by the funer	atio	1 Natural 5 Pending 2 Accident investigation	n	Day Year)	Injury	м	Work? 1 ☐ Yes	2 🗆 No					
Division	ii or Atte efter de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	288. Place of	Injury - At h etc. (Specif	ome, farm, st	reet, factory, of	fice		28f. Location (: City or To	Street and Numb wn, State)	er or Run	al Route Num	ber,
	To the Hospital or Attending Physician: within 24 hours effer death. To the Funerel Director: Affer this certific completely filled in by the funeral director.	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example	nysician: To the be niner: On the basis and manner	s of examina	owledge, deat ation and/or in	h occurred at to	ne time, dat my opinion,	e and place, death occur	and due to the red at the time,	cause(s) and ma date and place,	inner as s and due t	stated. to the cause(s)
	To the Within To the	Me	29b. Signature and title of fetifier	4	11		29c. Li	cense numb	per		29d. Date signe	d (Month,	Day, Year)	
) In	N. 1	1		C	.C.M.	E		NOV. 1	, 200	05	
	3		30. Name and address of person who											
1			JACK W. T. H. 31. Date filed (Month, Day, Year)	1 M.D	istrar's Sign	LLL PE	NN STRE	ET, B	ALTIM(ORE, MARY	LAND 21	201		
West of the second	Sta Registi		NOV 0 4 2005	32. Reg	, K	Loss	Le la la la la la la la la la la la la la							

			Fior 1 = State Registrar	State of		d / Depa	artment of H rtificate of I	lealth and I	Mental Hyg	9	5 35600
c. s	° Physici /Medio Examir	cal	Decedent's Name (First, Middle Waverly 4a. Facility Name (If not institution)	give street and numi	per)	Luck	4b. City, Town, or	r Location of Death	2. Date of Dea Month	Day Y	Death
	Funeral Director		Joseph Richy 5. Social Security Number 217-88-9756		Age (In yrs.	last birthday) Yrs.	Baltin	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 10-8-	h v, _{Year}) -65	A. Birthplace (State or Foreign Country) Md.
	death with the Maryland ms 23s or 28e-f show r.must be notified at	Director	Usual Residence of Decedent 10a. State 10b. County Md . NZ 10e. Street and Number	1	10c. Cit	y, Town or Lo Balti	imore				10d. Inside City Limits 1X Yes 2 □ No
	r death with tems 23s or 3s or 3s	Funeral Dir	2027 Jefferson	12. Was Deced	es?	.S. 13.	10f. Zip Code 212 Was Decedent of H f Yes, specify Cuba			10g. Citizen of Wh US	
3-003e	72 hours affe 'naturel', or l	by	Never Married 2 Marri 3 Widowed 4 Divorced 15. Decedent (Specify only highes	Year or Dat	es:	16a. Dece	1 ☐ Yes 2 ☑ No	Specify: ation		Specify: I	Black
and 2121	e filed within al Hygiene. I other then " vent, ILE NE	Be Completed	Elementary/Secondary (0-12) 7th grade 17. Father's Name (First, Middle, 1	College (1-4	lor 5+)	lite. I	aborer	0		Varies Maiden Sumame)	
Maryiai	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. I show proprents if them 27 is marked other then "naturel", or Items 23s or 28e-f show eny injury or other treumatic event, the Medical Erammar must be notified at Once.	Tof	Freeman 19a. Informant's Name/Relationsh Evelyna Nettle	_	Lucke nother	19b. Mailir	ng Address (Street a				ate, Zip Code)
paltimore,	nt. Pages 1 a artment of Hea ortent: If item njury or othe		20a. Method of Disposition 1	3 □Removal from St necify)	ate 20b. P	Place of Dispo emetery, crem Mt. Car	sition (Name of natory or other placemel Cem. Name and Address	9)		20c. Location - Ci	
Da Da	permi Depa Impo eny ir		23a. Part1. Enter the disease, or shock, or heart failure. List	mplications that cau	used the death	Ī	March F.H	. Łast	1101 E	timore, N . North A	Add. 21202 Ave. Approximate Interval Between Onset and Death
	hysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	ь	d Imm		leticiency	syndro	me		years
,00,00	cate be executed physician and the burial-transit	dicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequal						
.O. DOX 0	The taw fequires that the death certifical are has been signed by the attending phypage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2∏Fetai ntattime of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	,
cords, r	w requires that been signed t should be det	by	Part II. Other significant conditio	ns contributing to dea	th but not resu	ulting in the ur	nderlying cause give	en in Part I.	1 □ Y	es 2 No 3	ute to the cause of death?
	ien: Ine taw ntificate has l ctor, page 2 s	Be Completed	25. Was case referred to medical examiner?					26. Place of Dea	24a. Was a autops perform 1 Yes 2	sy prio med? dea 2 No 1	re autopsy findings available in to completion of cause of th? Yes 22 No
VIVISION OF V	To the Nospitel or Attending Prysicien: The law within 24 hours after death within 24 hours after death. To the Funerel Director: After this certificate has I completely filled in by the funeral director, page 2 s	Certification: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could in	ation	Injury Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injury Work M 1 🗆 Y	at Nursing H	ome 5 Reside	ence 6 Other ow injury occurred	(Specify) HOSPICE
	ospitel or At hours after d inerel Direct y filled in by		4 Homicide determi	ned 286. Place o building	est of my kno	viedge death	eet, factory, office	e, date and place,	City or Town	n, State)	or Rural Route Number, er as stated.
:	vithin 24 To the Fu	Medical	(Check only one) 2 Medical E 29b. Signature and title of certifier	exeminer: On the bas and manne	is of exam≀na!	tion and/or inv	29c. License	pinion, death occur	red at the time, d	late and place, and	I due to the cause(s)
	2		30. Name and address of person of ETSOMP RICE	tho completed cause	of death (Item	2	-	Balt	More M	D 2120	1, 2005
1	Sta Registr		31. Date filed (Month, Day, Year)	4.7	gistrar's Signa			12001			

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** NO♥EMBER Tay, 2005ar 12'. ZODM ANGELA L. LEWIS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3918 EMMART AVE. BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours Days 1□M 2**X**F Yrs. Director 217-66-7936 50 11-30-1954 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or Items 23c or 28a-f show the Medical Examinar must be notified at 1 X Yes 2 No N/A BALTIMORE Director MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 3918 EMMART AVE. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ YNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 □ Never Married 2 □ Married 1 Tes 2 No Maryland 21215-0036 Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) -12-SOCIAL WORKER STATE OF MARYLAND other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mental pe WILLIAM A. LEWIS HELEN GORDON Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 I KIMBERLY Y. COLEMAN(DAUGHTER) 3918 EMMART AVE. BALTIMORE, MARYLAND 21215 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ö 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or once. ^ 4 □ Donation 5 □ Other (Specify) ARBUTUS MEMORIAL PARK 11-7-2005 BALTIMORE, MARYLAND 21. Signature of Funeral Service License VERNON R. BAILEY 22. Name and Address of Facility VERNON BAILEY FUNERAL SERVICE Rum 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician OVARIAN YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) inding physician use as the buria Physician/Medical the 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 4☐Pregnant at time of death 5 Other (specify) signed by the a o 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown should should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy performed? 2 No 1 Yes 1 Tyes 2 No vision of Vital director. Be 25. Was case referred to medical 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOME 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) After thi HOSPICE 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ō To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11/3/2005 Name and address of person who completed cause of death (Item 23a) (Type, Print) PAUL PLACE BALTIMORE UNIGHT M.D 32. Registrar's Signature 31. Date filed (Month, Day, Year)

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		•	For State Registrar	Otate of ma	i y lai k	-			Death			Reg. No.	On	~	3570	10
	1.4		Decedent's Name (First, Middle, Last	it)					-		2. Date of De	ath			3. Time of De	ath
	Physici		KAthleen L	Asseth							Month	Day	20	ear سيان	2215	М
100	/Medic Examin		4a. Facility Name (If not institution, give				4b. City	, Town, or	Location of	of Death		_	County of		1	
			University of Maryl	and Medica	Cen	ten	43	HIA	mone							
- R	Funeral		5. Social Security Number 6. S	9x 7.Age □M 2∏xF	(In yrs. la	ast birthday)	If Unde Months	or 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th ly, Year)	9.	Birthp	lace (State or Fi	oreign
4.	Director		214-50-3700 1 Usual Residence of Decedent		51	Yrs.					6/21/1	954		Mar	yland	
	land ow		10a. State 10b. County		10c. City	, Town or Loc	cation							1	0d. Inside City L	imits
	Man,	to	MD Baltim	ore	Pa	arkvil.	le								1 ☐ Yes 2	₽No
	th the	irec	10e. Street and Number				10f. Z	ip Code				10g. Citi	zen of Wha	t Cour	try?	
	23a (Funeral Director	3720 Double Rock	Lane				2123	4				U.S.	Α.		
	teme teme	nuel	11. Marital Status	Was Decedent E Armed Forces?		S. 13. V	Vas Dec f Yes, sp	edent of Hi	spanic Ori n, Mexicar	igin? (Spe n, Puerto l	cify Yes or No Rican, etc.))-	14. Race - Black,			
36	s aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	0	1	☐ Yes	2€ No	Specify:				Specify:	Whi	te	
8	filed within 72 hours after death with the Maryland Hygiene. Ither than "naturel", or teme 23a or 28a-f show int, it e Medical Evarul et must te motified at	edr	15. Decedent's Ed			16a. Deced	lent's Us	ual Occupa	ation			16b. Ki	nd of Busin	iess/Ind	lustry	
215	n n	piet	(Specify only highest gra		.,	(Give I	kind of w OO NOT	ork done d use retired	during mos)	t of workii	ng				,	
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ng	al Hy al Hy d oth	Be	17. Father's Name (First, Middle, Last)						18. Mothe	er's Name	(First, Middle	, Maiden	Sumame)			
yla	Meni	ဂ္	James Hamilton Re								a J. 0					
Maryland 21215-0036	12 sh and remm		19a. Informant's Name/Relationship (•				Route Numb				·	
e,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel; or Iteme 23a or 28a-f show any injury or other traumatic event, Ite Mudical Examinet must be notified at ance.		Robert Lasseth/] 20a. Method of Disposition	nusband	20b. Pl	ace of Dispos			ock 1		rarkvi		Mary cation - Cit		d 21234	
Baltimore,	Pages nent of I ant: If Its ary or o		1 ☐ Burial 2 ☐ Cremation 3 ☐		CE	ometery, crem Comfo	natory or	other plac		11/4	/05				Virgin	
Ħ	artme orten Injur		4 □Donation 5 □Other (Specify 21. Signature of Funeral Service Licen		110				1						l Home	
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			23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications that caused	the death										Approximate Interval Between	en
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	/Medical		resulting in death)	Due to (or as a	consequ	ence of):	0,0									
\$-5 -	Examiner		Sequentially list conditions,	b												
1	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequ	ience or):										
<u>۔</u> مہ	be executed sician and burial-transit	xar	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a	consequ	ience of):			-					-		
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9	tificat ng phy as th															
P.O. Box	th cer tendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			Ectopic	pregnancy				2	23d. Date o		,	
Э. Н	e dea	Physician/Med	in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown	4☐Pregnant at 9☐ Unknown			Other (s						Month		Day Yea	ŗ
<u>a.</u>	that the death certifical ed by the attending phi detached for use as th	٩ ک	Part II. Other significant conditions c	ontributing to death bu	t not resu	Iting in the ur	adertvina	Callse dive	an in Part I		23e Did I	obacco u	se contribu	ite to th	e cause of deat	th?
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Re	he la e has	E C									auto	psy ormed?	prio dea	r to cor th?	npletion of caus	
ta	en: T tificat tor, p	0	25. Was case referred to medical						26. Place	of Death	(Check only	2) No	10	Yes	2 No	
<u> </u>	Physician: The lav this certificate has al director, page 2	To B	exa <i>m</i> iner? 1 □ Yes 2 X No	Hospital:	nt 2 🗆 i	ER/Outpatien	t 3 🗆 🖸	OA Cthe	25		ne 5□Resi		5 □Other (Specify	')	
0	ng Ph fter th neral		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Day	Year)	28b. Time of Injury		28c. Injun Work	at c?	2	28d. Describe	how injur	y occurred			
Siol	endir eath. or: Al	catic	2 ☐ Accident investigation				М		Yes 2 🗆	No						
Division of	i Site	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ry - At ho. . <i>(Specify</i>	me, farm, stre	eet, facto	ry, office		4	28f. Location (City or To			or Rura	l Route Number	•
	To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a, Certifier 1 Certifying Ph	ysician: To the best of	f my kno	wledge door	3 000:	d at the time	ne date an	d place	and due to the	Caline(s)	and mana	25.00.00	ated	
	Hos 24 hc Fun etely	Medicai	(Check only 2 Medical Examone)	niner: On the basis of and manner sta	examinat	ion and/or inv	estigation	n, in <i>m</i> y o	pinion, dea	th occurr	ed at the time,	date and	place, and	due to	the cause(s)	
	To the Hospitel within 24 hours a To the Funeral completely filled	Me	29b. Signature and title of certifier				2	9c. License	number			29d. Dat	e signed (A	Aonth,	Day, Year)	
•			12 bilas	-MD				Pi	165	0		00	T 31	2	005	
	,1		30. Name and address of person who	completed cause of de				*								
	1 1		Robert S Ander				Gre	ene.	Stree	et B	Alt.nor	em	0 21	20	1	
	Sta Registi		31. Date filed (Month, Day, Year) NOV 0 4 200	5. Registra	rs Signat	ure	the									

ivision of Vital Records, P.O. Box 68760, Programme Baltimore, Maryland 21215-0036	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Medical Certification: To Be Completed by Physician/Medical Examiner
Division of Vi	To the Hospital or Attanding Phyalci within 24 hours after death. To tha Funaral Diractor: After this cen completely filled in by the funeral direct	dical Certification:

Physician /Medical Examiner

Funeral Director

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For State Registrar			State	or iviaryia	and / Dep			neaim Death		nent	аі пу	_	00	() pus	O P**	~ ~ .
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5. Social Security N	umber	6. Sex	м 2 X) F		rs. last birthda	/) If Uni	der 1 Year	If Under Hours	24 Hrs. Min.	8. Da	ate of Bi	rth ay, Ye.		9. Bir	thplace (State	or Foreign
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Usual Residence of 10a. State	10b. County	,		10c.	City, Town or I	ocation									10d. Inside	City Limits
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10e. Street and Nun							Zip Code					10g.	Citizen of	What Co	ountry?	
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Elementary/Secon	ndary (0-12)		College (1-4or 5+)		nking		u)				Ra	nk Er	nn1a	3700	
17. Father's Name ((First, Middle,	Last)			Dai	IKTILE	<u> </u>	18. Moth	er's Nam	e (First	t, Middle		len Sumai		yee	
Virgil E	rnest	Move	2					Fai	nnye	Re 1	۵۱ ا	Δnt	honv			
19a. Informant's Na					19b. Mai	ling Addre	ess (Street	and Numb						State,	Zip Code)	
Carol Bu	rke (D	augh	nter)		8133	Sene	ca Vi	Lew Di	r., (Gait	her	sbu	rg, N	1D 2	0882	
20a. Method of Disp					. Place of Disp cemetery, cr	osition (f	Vame of	1		Date					Town, State	
1 A Burial 2 [1 4 □ Donation			emoval from	State M	aple H				10/27	7/05	5	Po	rtlar	nd, '	TN	
21. Signature of Fu	neral Service	License	10					ss of Facili		l II.						
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23a. Part1. Enter the shock, or hear	ne disease, o rt failure. List	r complice	e cause on	caused the de	eath. Do not e	nter the m	node of dyir	ng, such as	cardiac	or resp	iratory a	rrest,			Approxim Interval B	etween
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that initiated events resulting in death) L	;	c		or as a cons	Mellitu	ıs	_	_	-			-		-		
,				oxia	oquence on.									l l		
		d	P	02124								_				
IF FEMALE: 23b. Was decedent	t orogoant	23	3c. If yes, ou	tcome of pre	gnancy								23d Da	te of del	iverv	
in the past 12	months?			birth 2 □ F nant at time o		☐Ectopic☐ Other	pregnancy (specify) _	/					1	onth	Day	Year
9 ☐ Unknown			9□ Unkr	iown												
Part II. Other signif	icant conditi	ons con	tributing to o	leath but not	resulting in the	underlyin	g cause giv	en in Part	l.	2	3e. Did 1	tobacc	o use con	tribute to	the cause of	death?
Respira	tory F	ailu	ıre								1 🗆	Yes	2 X No	3 🗆 Pr	obably 4]Unknown
										2	4a. Was		24b.	Were au	utopsy finding	s available
										11	auto perfo □ Yes	psy ormed 2	?	death?	completion of 2□ No	cause of
25. Was case referrexaminer?	red to medica	ıl _						26. Place	e of Deat							
1 ☐ Yes 2X	No	Н	ospital: 1 🗆	Inpatient 2	☐ ER/Outpati	ent 3	DOA Ott	ıөг: 4. Х N	ursing Ho	me 5	□ Resi	dence	6 □Oth	ner (Spe	cify)	
27. Manner of Deatl	h 5 □ Pendii	na	28a. Date (Mor	of Injury oth, Day Year	28b. Time Injury	of	28c. Injur Wor	y at k?					jury occur			
2 Accident 3 Suicide		igation				М		Yes 2								
4 Homicide	deterr		28e. Plac build	e of Injury - A ling, etc <i>. (Sp</i> e	t home, farm, s ecify)	treet, fact	ory, office			28f. Lo	ity or To	Street wn, St	and Numt ate)	oer or Ru	ıral Route Nu	m <i>ber</i> ,
DOS CONTROL	1 N Contifut	na Dhua	deines Tarb	- b - st - f !		sh			- d = (a = a =				(-)			
29a. Certifier (Check only one)	2 Medical	Examin	er: On the t	e best of my i pasis of exam iner stated.	knowledge, dea ination and/or	nvestigati	on, in my o	ne, date ar pinion, dea	nd place, ath occurr	and du red at t	ie to the he time,	date a	(s) and mand place,	anner as and due	s stated. to the cause	(s)
29b. Signature and	title of certifie	∍r	and mar	iller stated.		12	29c. Licens	e number				29d. l	Date signe	d (Monti	h, Day, Year)	
	hon			Pusa	010		חחח/	7330							2005	
30. Name and addre						Print)	7004	0,00					coper	۷4 و	, 2005	
					0 Edmor		Dr	Rock	vill	e.	MD 3	208	52			
Thomas V 31. Date filed (Moni	th, Day, Year,			Registrar's Sig		1	,			-,						
NC.)V U 4	ZUUD	J. Com	alger A	in the											

DHMH 17 Rev 1/2001

State Registrar

		State of Ma		artment of Health and I	•	iene -	0.00
		1 = For State Registrar		rtificate of Death		2005	35702
Physic	ion	Decedent's Name (First, Middle, Last)			2. Date of Deat Month	h Day Year	3. Time of Death
/Med		Joyce L. Meizen				r 2, 2005	1:20 P M
Exami	iner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death	1	4c. County of Death	
Funoral		Sunrise Assisted Living 5. Social Security Number 6. Sex 7. Age	e (In yrs. last birthday)	Pikesville If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,	Baltimo 9. Birth	re pplace (State or Foreign untry)
Funeral Director		179-30-4178 1□M 2☒F	68 Yrs.	Months Days Hours Min.	(Month, Day, August	9,1937 Pe	nnsylvania
D .		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Le	cation			10d. Inside City Limits
Aanyla I sho	ō		Ellicott				1 ☐ Yes 2 🔀 No
the 1	Director	Maryland Howard 10e. Street and Number	ETTTOOLI	10f. Zip Code	10	0g. Citizen of What Co	**
th with	aiD	4590 Doncaster Drive		21043		USA	
ams ams	by Funeral	11. Marital Status 12. Was Decedent E Armed Forces?		Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerlo	pecify Yes or No- Rican, etc.)	14. Race - Ame	
s afte	Y.	1 Never Married 2 Married 1 Yes 2 No 1 Yes, Give Year or Dates:	lo	1 ☐ Yes 2X No Specify:			ite
2 hour	ed	15. Decedent's Education	16a Dece	dent's Usual Occupation		16b. Kind of Business/I	
hin 72	plet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	(Give	kind of work done during most of wor DO NOT use retired)	king		•
ed wit ygjene ygjene ygjene ygjene ygrith	Completed	Elementary/Secondary (0-12) College (1-4or 5 5+	Edu	cator		Teacher/Ed	ucation
be fill htal H	Be	17. Father's Name (First, Middle, Last)			ne (First, Middle, N	•	
should be filed within 72 hours after death with the Maryland should be filed within 72 hours after death with the Maryland and Mental Hygiene. In marked other than "natural", or Itams 23a or 28e-1 show unatic event, it a Madical Exeminar must be notified at	2	Warren Lentz 19a. Informant's Name/Relationship (Type, Print)	19b Maili	ng Address (Street and Number or Ru	Cleanor M		in Code)
I co, Middly Indian A 12 10 0000 I and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene. Item 27 is marked other than "natural", or Itams 23s or 28s-1 show other treumatic event, it a Modical Examinar must be maillifed at		David J. Meizen, Son		Doncaster Drive H			
s 1 a		20a. Method of Disposition	20b. Place of Dispo	osition (Name of matory or other place)		20c. Location - City or	
Pages nent of hent: If its ury or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify)		1	03/05	Baltimore,	Mary land
permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre-		21. Signature of Funeral Service Definses	2	2. Name and Address of Facility Cremation Society	Of Marvl	and Inc.	Second research
		Thomas Gregor/		199 Frederick koac	L Baltimo	re. Maryla	
54		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin Immediate Cause (Final			or respiratory arre	951,	Approximate Interval Between Onset and Death
Physician /Medical		disease or condition a. Ovari	an Cancer a consequence of):	with Metastases			Yr
Examiner		Alzhe	eimer type	Dementia			Yrs
p ti	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of):				
and I-trans	Examiner	that initiated events c. Due to (or as a	a consequence of);				
The color us, F.C. box oor oo; The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the buriat-transit	calE						
difficate g phy as the							
th cer tendin	an/N	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth		DEctopic pregnancy		23d. Date of deli	*
the at	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 9 □ Unknown	time of death 5	Other (specify)		Month	Day Year
that the ed by detact			ut not resulting in the u	inderlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
uires uires lid be	d by				1	s 2 No 3 Pro	obabiy 4 🗆 Unknown
aw req	ompieted				24a. Was ar		opsy findings available
vical necessity serial	E O				autopsy perform	ned? death?	ompletion of cause of 2 No
ysicien: The lis certificate hadirector, page	BeC	25. Was case referred to medical examiner?			th (Check only one	21	Aggi altad
	은	1 ☐ Yes 2 X No Hospital: 1 ☐ Inpatie				nce 6X Other (Spec	Assisted Living
nding Phys th. : After this stuneral di	tion	1 X Natural 5 ☐ Pending (Month, Da) 2 ☐ Accident investigation	Year) Injury	Work? M 1 ☐ Yes 2 ☐ No	28d. Describe ho	w injury occurred	
Atten	ifica	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Inju	ury - At home, farm, st	reet, factory, office	28f. Location (Str City or Town	reet and Number or Ru	ral Route Number,
rs after sed in lead in lead in l	Certification:	4 Homicide Scientifica building, etc	з. (эрөспу)		City of Town	, State)	
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical		examination and/or in	th occurred at the time, date and place exestigation, in my opinion, death occu	and due to the ca	use(s) and manner as ite and place, and due	stated. to the cause(s)
o the o the	Med	29b. Signature and title of certifier	ited.	29c. License number	29	d. Date signed (Month	, Day, Year)
► S ⊢ Ö		Illen Keill	4 mD	D54749	N	lovember 3,	2005
10		30. Name and address of person who completed cause of d	th (Item 23a) (Type,	Print)	-		
Ų		Allen Reilly, MD 4 East Ro	lling Cros	s Roads, Baltimor	e, Maryla	and 21228	
S Regis	tate trar	31. Date filed (Month, Day, Year) NOV 0 4 2005	ar's Signature	W			
		INC. A TOTAL	-				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month RIOTT OVEMBY 2005 /Medical 4a. Facility Name (If not institution, give streemand number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MIMORI TIMORO orning d If Under 1 Year Months Days If Under 24 Hrs. Hours Min. Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 F 219-30-1761 Usual Residence of Decedent Director BALTIMORE, MO filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-1 show injury or other traumatic event. The Medical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2 Do Funeral Director DMORE TMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? वेवे 21231 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 17 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1□Yes 20 No Specify þ 3 Widowed 4 ☐ Divorced Year or Dates: Jhite, Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) romemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental 2 Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or permit. Pages 1 and 2 s Department of Health an Important: If item 27 Is. any injury or other traus DRMAN llen 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. 20c. Location - City or Town, State 4 Donation 5 Other (Specify) RKU, 11e 21. Signature of Funeral Service Licenses 21234 22. Name and Address of Facility BA. TIMORE, MD WADS FUNERAL CHAPEZ SOCIO HARFORD 23a. Part1. Enter the disease, shock, or heart failure. Li crimplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one lasts on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ference Dementia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 ponths?
1 Yes 2 No
9 Unknown Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown s been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 1000 24a. Was an autopsy perform 2 **X** No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Certification: To

To the Hospital or Attending Physician: The law requires that the death certificate be executed this certificate funeral director, After death. Director: filled in by the within 24 hours after To the Funeral Dire

1 Yes 2 No 27. Manner of Death

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

gistrar's Signature

4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred

Natural 5 Pending investigation 2 Accident 3 Suicide 6 Could not be 4 Homicide

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

31. Date filed (Month, Day

Certifying Physician: To the best of my knowledge seath occurred at the time, date and blace, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

Fenberd

D0059423

November3, 2005

30. Name and address of person what impleted cause of dwith (Item 23a) (Type, Print) Bood Samuritan

4 2005

Hospital Prof Building Bultimore, MD 21239 批

State Registrar

Medical

		1	For State Registrar	State of Maryla	•	artment of rtificate o			Reg. No.)5 357 . ll
Ī	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last,	EYERS				2. Date of D Month		Year 19,30pm
1	Examin		4a. Facility Name (If not institution, give				n, or Location o		4c. County	
			NORTHWEST HOSPITA 5. Social Security Number 6. Se		s. last birthday,	If Under 1 Ye		24 Hrs. 8. Date of B	irth	IMORE 9. Birthplace (State or Foreign
u	Funeral Director		215-24-3418		77 Yrs.	Months Day	ys Hours	SEP.1	1,1928	Country) MD
	and w		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limits
	Maryli -f eho	tor	MD BALTIMOR	RE F	RANDALLS	STOWN				1 ☐ Yes 2 ☑ No
	or 28a	Director	10e. Street and Number			10f. Zip Cod	le		10g. Citizen of	
	ath wi	ral	9109 LIBERTY ROAL		110		21133	:- 2 (CtV	14 Pos	USA ce - American Indian,
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: if item 27 is marked other then "naturel; or iteme 23s or 28s-f show says injury or other traumatic event, I'm Madical Exp. illustrated to notified at ADEs.	by Fur	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	0.5.	Was Decedent of If Yes, specify O		gin? (Specify Yes or N , Puerto Rican, etc.)	Bla	ck, White, etc.
21215-0036	72 ho	Completed	15. Decedent's Edu (Specify only highest grad		16a. Dece	edent's Usual Oc kind of work do DO NOT use re	cupation one during most	of working	16b. Kind of B	usiness/Industry
121	within ane.	idu	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use re	'A		N,	/A
d 2	Hygie other	e Co	17. Father's Name (First, Middle, Last)				18. Mothe	r's Name (First, Midd	e, Maiden Sumar	me)
/lan	Vental	To Be	NATHAN		GUL			TTIE		REISMAN
Maryland	d 2 sho th and lith a		19a. Informant's Name/Relationship (T) HAROLD GULLAN /	уре, Print) BROTHER				r or Rural Route Num ENUE – PHI		, State, Zip Code) A, PA 19119
	of Hearlitem		20a. Method of Disposition	200	Place of Disn	osition (Name or ematory or other	1	Date		- City or Town, State
Ē	Page ment c ant: If ury or		1 🕅 Burial 2 □ Cremation 3 □1 4 □ Donation 5 □ Other (Specify,		ETH EL	MEMORIAL	PARK	11/03/2005		ALLSTOWN, MD
Baltimore,	permit. Departi import		21. Signature of Funeral Service Licens	atter			STERST	OWN ROAD -	PIKESVI	ROS., INC. LLE, MD 21208
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the de					arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a cons		ENCE	1117 00	PATHY	<u>.</u>	
	Examiner		Carriantia III. list equiditions	b						
-	be sit	iner	Samuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	өциөпсө от).					
	te be executed ysicien and se burial-transit	Examiner		c. Due to (or as a cons	sequence of):					
68760,		cal		d						
Box.	death certific e ettending p nd for use as i	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	□Ectopic pregna □ Other (specify				ate of delivery onth Day Year
ds, P.O.	sign d be	þ	Part II. Other significant conditions of DEMENTIA,	ontributing to death but not BLNO CAR			e given in Part I			atribute to the cause of death?
of Vital Record	The law requiete has been page 2 should	Completed	ASPIRATION PN	amounds				ре	opsy formed?	Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
ital	ician: Th certificete rector, pag	0	25. Was case referred to medical				26. Place	1 ☐ Yes of Death (Check only		10 163 20 10
>	S 5	To B	1 Tes 2 THO	_	ER/Outpatio			rsing Home 5 Re		
	ding Ph h. After th funeral		27. Minner of Pending	28a. Date of Injury (Month, Day Year	28b. Time Injury		Injury at Work? 1 ☐ Yes 2 ☐		e how injury occu	rred
Division	deat deat ctor: y the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.	At home, farm, s ecify)			28f. Location	(Street and Num own, State)	ber or Rural Route Number,
	To the Hospital or / within 24 hours after To the Funeral Direction Completely filled in b	edicai Ce		ysician: To the best of my liner: On the basis of exam and manner stated.						
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.		29c. Lie	cense number		29d. Date sign	ed (Month, Day, Year)
	⊢ s ⊢ ō		> RROWE,	major	MP	\mathcal{D}	5428	38	octos	e1295 2005
	1		30. Name and address of person when	completed cause of death (Item 23a) (Typi PA JAN	e, Print)	leverth	vest Hosy	IMAL C	ENTOR
*	St Regist	ate rar	31. Date filed (Manth Day Year) 20	05 Registrar's Si	gnature	edi)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Items 23a 20d per Droc (849 11/04/05dbb) Mental Hygiene

Amend Items 25,27,28a-f per inc. (848 10/25/05dbb)

Item 18 per FH

Reg. No. 35705 1 - State Registrar Item 18 per FH 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** PM Shepherd 4:15 McDuffle Sep tember 35 2005 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Johns Hopi 5. Social Security Number Bayview Baltimore Med. Ctr. Hopkins 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2□F Months Director 250-38-8521 80 11-26-1924 SC Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or than "natural", or itema 23a or 28a-f ehow the Medical Examiner must be notified at MD BALTIMORE TURNER STATION 1 X Yes 2 ☐ No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 HENRY STREET 21222 USA tiled within 72 hours after deeth Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: BLACK þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 STEELWORKER BETH. STEEL other 17. Father's Name (First, Middle, Last) 18 Mother's Name (Eirst Middla Maiden Surname)
Lula Bell Williams Be Pages 1 and 2 should be 1 nent of Health and Mental I ant: If item 27 le marked o WILLIE MCDUFFIE **EDITH DELORES JOHNSON** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 675 N. AVONDALE ROAD, TURNER STATION, MD 21
Disposition (Name of Date 20c. Location - City or Town, State EDITH DELORES JOHNSON/DAUGHTER Mu 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If eny injury or once. ARBUTUS MEM. 09/28/2005 BAITIMORE, MD * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 1701 LAURENS STREET, BALTO., MD 21217 mas 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition Neurogenic Shock Modes resulting in death) /Medical Due to (or as a consequence of): Examiner Cervical spine trauma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner CERTIFICATION APPROVED BY WELLOW EXAMINER The law requires that the death certificate be executed burial-transit Accidental fall and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physicien Ethanol intoxication Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) the detached à been signed bestored better Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Tes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Mes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Inpatient 2 EP/Outpatient 3 DOA s after dea. this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? fel1 1 Manual 5 Pending investigation 09/21/2005 11:20p 1 ☐ Yes 2 🙀 No 2 Accident Subject was intoxicated and 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 5 8 Flemming Dr, Dundalk, MD at home To the Hospitel within 24 hours a To the Funeral L 12 Centifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the eause(s) and manner as stated Medicai 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Odrien & Janvier, MD, PhD Res-000 September 22,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9990 Eastern Auchus Harien Janvier Builtimore, and 21329 32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 2 5 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend State of Maryland Department of Health and Mental Hygiene 0 0 5

35706 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death McFadden Day November 2nd 2005 **Physician** mangarel /Medical 4a. Facility Name (It not institution, give street and number)
HOWARD COUNTY GENERAL HOSPILET 4b. City, Town, or Location of Death Examiner Columbi If Under 1 Year If Under 24 Hrs. 8. Date of Birth
| Hours | Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 F 215-22-5310 Yrs March 19,1921 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Exeminer must be notified at 1 ☐ Yes 2√ No Directo MARYland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? or items 23a or 2902 21234 Church Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No þ Specify. "naturel", 16b. Kind of Business Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9 yrs. Homemaker Own Home 7 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H sant: if item 27 is marked other. William Vincent Jositis Margaret Eva Nauyalis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 115 Felton Road Lutherville, Md. 21093 William Jositis(Brother) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 6 Department of important: if eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Greenmont Crematory 11-04-05 Baltimore Md. permit. 21. Signature of Funeral Service 22 Name and Address of Facility Mitchell-Wiedefeld F.H. Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cable on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) I hoch with gram **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit YOLD Due to (or as a consequence of) attending physician for use as the buria allere by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23d. Date of delivery 3 □Ectopic pregnancy signed by the atte Month Day Year 4□Pregnant at time of death 5 Other (specify) o. 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 □Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 2.0 No 1 Yes of Vital To the Hospital or Attending Physician: : After this certification at the standard director. 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Medical Certification: 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Zimedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and title of certifler November 29c. License number 50870 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lane Clarkselle MD 5005 Signal Bell 31. Date filed (Month, Day, Year) State Registrar

32. Registrar's Signature

Germ & Speck

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 15

Certificate of Death 3. Time of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Day **Physician** November 3, 2005 1:45AM O'LEARY JANE /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Name (If not institution, give street end number) Examiner Baltimore Saint Joseph's Nursing Home Catonsville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/20/1920 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. lest birthdey) **Funeral** Days Min Hours 1 ☐ M 2 🔀 F Yrs Maryland 85 219-01-0263 Director Usuel Residence of Decedent 10d. Inside City Limits death with the Merylend 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumetic event, the Medical Examiner must be notified at 1 Yes 2 □ No N/A Baltimore Maryland Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 21231 United States 2106 Bank Street Funerai Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. o filed within 72 hours efter de l'Hygiene. other than "natural", or Item 1 ☐ Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 ☐ Divorced 2 White Year or Dates Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Domestic Homemaker 8 Demit. Peges 1 end 2 should be filed to Depertment of Health end Mentel Hygie important: If Item 27 1s marked other 1 any injury or other traumatic event, # 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be Aniela Malec Jan Wojcik 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. informent's Name/Relationship (Type, Print) 2106 Bank Street Baltimore, Maryland 21231 Jeannette Krol - Daughter 20b. Place of Disposition (Neme of cemetery, crematory or other plece)
MeadOwridge 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 11/7/05 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park 21. Signature of Funeral Service Licensee 22. Name end Address of Facility David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, MD 21231 ipplications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one ceuse on each line. 23a. Pert1. Enter the disease, or o shock, or heart failure. List Approximate Interval Between Onset and Death **Physician** 10 YEARS BREAST CANCER Immediate Cause (Final diseese or condition resulting in death) /Medical Examiner Due to (or es a consequence of): Physician/Medical Examine Hospital or Attending Physician: The law requires that the death certificate be executed ettending physician and for use as the bunal-transit Due to (or es e consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury Division of Vital Records, P.O. Box 68760 that initieted events Due to (or as a consequence of): resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the e 1 □ Yes 2 □ No 3 □ Probably þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? been si Completed pege 2 s 2 No 1 🗆 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpetient Other: Nursing Home 5 - Residence 6 - Other (Specify) 2 ER/Outpetient 3 DOA 2 1 Tes 2 No nous after deeth.

neral Director: After this y filled in by the funerel di this 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 27. Menner of Death edicai Certification: 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide within 24 hours a
To the Funeral C Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

I Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) and menner stated. (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture and title of certifier 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) SUITE DOY, CATCHSULE, MAYLAND 21228

31. Date filed (Month, Day Year) 31. Date filed (Mont 32. Registrar's Signature

DHMH 16 Rev 6/95

State Registrar

ORIGINAL

		4	•	State of Maryland	d / Depa		lealth a	and Men	tal Hygie	•	35709
	Physicia /Medic Examin	al	4a. Fecility Name (If not institution, give st. Washington Adve	reet and number) entist Hosp		Sr. 4b. City, Town, o Takon	ıa Pa	of Death rk	Date of Death Month Ctober	Day Year 30,200 4c. County of Dea Montgon	nery
	Funeral Director		5. Social Security Number 6. Sex 224-26-3854 1型 Usuel Residence of Decedent	7. Age (In yrs. la	O Yrs.	If Under 1 Year Months Days	If Under	Min. (/	Date of Birth Month, Day, Y an. 1	9. Bi 1,1925	thplace (State or Foreign ountry) VA
	he Maryland (8a-f show offited at	ector	MD 10b. County MD Montgome	,	lver	Spring			40-	033	10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	h with t	ai Dir	10e. Street and Number 8505 Springvale	Road		10f. Zip Code 20910	1		109	. Citizen of What C USA	ountry :
0000	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural; or Itams 23s or 28s-f show aumatic event, the Medical Exam har must be notified at	by Funeral Director	11. Marital Status 1: 1 Never Married 2 Married 3 XWidowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WWI		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No			Yes or No- n, etc.)	14. Race - Am Black, Whi	te, etc.
0-61717	l within 72 ho iene. r than "natur the Wedical	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)		dent's Usual Occup kind of work done DO NOT use retired nent Pro			16	b. Kind of Business Payco	/Industry
yiand	should be filed and Mental Hyg s marked other umatic event,	To Be C	17. Father's Name (First, Middle, Last) Oscar Printz]	Elizal	oeth I		
<u> </u>	s 1 and 2 should f Health and Men item 27 is marke other traumatic		Jackson T. Print							ity or Town, State,	
more,	Pages 1 ar nent of Hea int: If item; iry or other		20a. Method of Disposition 1 Burial 2 X Cremation 3 Re 4 Donation 5 Other (Specify)	20b Pt	ace of Disno	osition (Name of matory or other place Memori 1 Home	1	Nov Date	20	c. Location - City of	Town, State
bairimor	permit. Pages Department of I Important: If it any injury or o		21. Signature of Funeral Service Ligensey		22	2. Name and Addre	ss of Facilit	y Fair k Rd.	rfax M Fair	lemorial fax, VA	22032
,00,	Physician /Medical Examiner properties on the prival-transit properties of the prival properties of the prival properties of the prival properties of the pr	icai Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consequence to (or as a consequence) Mr Hally() Due to (or as a consequence) Mr Hally() Due to (or as a consequence)	ence of): W(A ence of): 5 LY			cardiac or res	piratory arrest		Approximate Interval Between Onset and Death
O. Box 68	that the death certificate bed by the attending physic detached for use as the b	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3	□Ectopic pregnancy	/	17-2		23d. Date of de Month	llivery Day Year
cords, r.	gn ga		Part II. Other significant conditions cont	ributing to death but not resu	lting in the u	nderlying cause giv	en in Part I.				o the cause of death?
аі жесо	The ate h	Completed							24a. Was an autopsy performa 1 Yes 2	prior to	utopsy findings available completion of cause of
5	ysician: Th is certificate director, pag	o Be	25. Was case referred to medical examiner?	ospital: 1 Inpatient 2	PVOutpatier	nt 3□ DOA Oth	OF:		eck only one)	ce 6 □Other (Spe	acufu)
lon of	ng Ph fter th meral	\vdash	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation		28b. Time o Injury	f 28c. Injur Wor	y at	28d.		injury occurred	,
DIVISION	i Sir d	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hos building, etc. (Specify)				City or Town, :	State)	ural Route Number,
	Hospital 24 hours a Funeral I etely filled	Medical	29a. Certifier (Check only one) Certifying Physical Examin	cian: To the best of my know er: On the basis of examinati and manner stated.	vledge, deati ion and/or in	h occurred at the tir vestigation, in my o	ne, date an pînion, dea	d place, and o th occurred at	due to the caus the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier			29c. Licens	e number	- 7	29d	. Date signed (Mon	th, Day, Year)
	1		30. Name and address of person who cor	npleted cause of death (Item 760 38. Registrar's Signat	23a) (Type,	Print)	808	3		10/301	05
)		IAVIM V- WAST M	7 76 O	ure /	GRROII	AVE.	Tak	ona t	ack, MU	20912
	Sta Registi		NOV 0 4 2005	Clave to	Apa	de					

1 - For Stata Registrar

			Decedent's Name (First, Middle, Last)				2. Date of Death	- Luc	3. Time of Death
	Physici		Edward Lo	uis Petzol	Ldt		NOY O	Day 2005	3:00PM
	/Medio	_	4a. Facility Name (If not institution, give street and n			r Location of Death		4c. County of Death	
		•	ST. AGNES HOS	SPITAL	1	BALTIMO	RE	N/	A
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birth	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yes JUL 28, 1	9. Birth	place (State or Foreign intry)
	Director		519-18-7607 ¹ X ^M ^{2□} F	80 Y	rs.		JUL 28, 1	925 Cali	fornia
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	/anyl	ō	Maryland Baltimore		Cat	onsville			1 ☐ Yes 2 No
	the 28a-	Directo	10e. Street and Number		10f. Zip Code	OHSVILLE	10g.	Citizen of What Cou	untry?
	3a or	Ö	234 Ridgeway Road			21228		USA	
	ours after death with the Maryland el', or Items 23a or 28s-f show Exactivat must be rotified at	Funeral	11 Marital Status 12. Was De	cedent Ever in U.S. Forces?	13. Was Decedent of H		city Yes or No-	14. Race - Amer Black, White	
စ္	or Its	Fu	1 Never Married 2 Married 1 XYes	2 □ No	1 ☐ Yes 2 X No		noan, etc.)	Specify: Wh:	
21215-0036	72 hours after "natural", or Its	d by	3 ☐ Widowed 4 ☐ Divorced Year or	Dates: 1943-75					
<u>.</u>	72 B B	Completed	15. Decedent's Education (Specify only highest grade completed	d) (Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of working	16b	. Kind of Business/li	ndustry
12	il Hygiene. other then "	E D	Elementary/Secondary (0-12) College	(1-4or 5+)	ieutenant (U.S. Airf	orce
	filed Hygir other	ပိ	17. Father's Name (First, Middle, Last)		reacenance		(First, Middle, Maid		.0100
Maryland		To Be	Louis Petzoldt			Winifre	d Bundage		
ž	d 2 should be th and Mental 7 is marked traumatic sv	-	19a. Informant's Name/Relationship (Type, Print)	19b.	Mailing Address (Street				ip Code)
	コミトラ		Courtney Marchese/Daugh	nter 1	2 Payson Av	renue Cat	onsville,	MD 21228	3
ore,	of Healt item 2		20a. Method of Disposition 1 ☐ Burial 2 ② Cremation 3 ☐ Removal from	comoton	Disposition (Name of r, crematory or other plan		ate 20c	. Location - City or T	Fown, State
Ĕ	Page nent ant: If		4 □ Donation 5 □ Other (Specify)		rematory, I	11/3/9	05	Baltimore	. MD
Baltimore,	permit. Pages 'Department of Himportant: If ite any injury or of once.		21. Signature of Funeral Service Licensee	len	22. Name and Addre	ess of Facility Cre	mation So	ciety of	MD. Inc.
_	907 2 9		Edward A. Gregorch		1	erick Road		re, MD 21	
% -₩.			23a. Part1. Enter the disease, or complications tha shock, or heart failure. List only one cause or	t caused the death. Do no each line.	ot enter the mode of dyir	ng, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
	Physician		tmmediate Cause (Finat disease or condition	TRA CE	REBRAL	BLE	SDING		DAYS
	/Medical Examiner		resulting in death)	o (or as a consequence o	f):				
· .	18	_	Sequentially list conditions, b.	U (u. as a curisequence U	15				
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	deat	Sicia	In the past 12 months? 1 □ Yes 2 □ No 4 □ Pre	gnant at time of death	5 Other (specify)	,	-	Month	Day Year
0.	at the de by the stached	Physici	9 Unknown				Tax and		
	The law requires that the de tte nas been signed by the a bage 2 should be detached t	5	Part II. Other significant conditions contributing to	death but not resulting in	the underlying cause gr	ven in Part I.			the cause of death?
pic	v requir been s should	ted					1 L Yes		obably 4 Unknown
ပ္	law Inas be	ple					24a. Was an autopsy	24b. Were aut	topsy findings available completion of cause of
正		Completed					performed 1 ☐ Yes 2 🗹	No 1 ☐ Yes	2□ No
/ita	ician: certifice rector, p	Be	25. Was case referred to medical examiner?	#1-10-13	1 04	26. Place of Death	(Check only one)		
of	this al dii	은		Dinpatient 2 ☐ ER/Out te of Injury 28b. Ti	patient 3 DOA		ne 5 Residence	e 6 □Other (Spec	cify)
n	ding f	lon	1 ☑Natural 5 ☐ Pending (M		ijury Wo	rk?]Yes 2 □No	od. Describe now i	illary occurred	
Division of Vital Records,	death death ctor: / the	Certification:	3 Suicide 6 Could not be	ce of Injury - At home, far			28f. Location (Street	t and Number or Ru	ral Route Number.
ĕ	after Dirs	ertii	4 Homicide determined 209. File	lding, etc. (Specify)	,		City or Town, S	tate)	
	To the Hospital or Attand within 24 hours after death To the Funeral Director; completely filled in by the	a C	29a. Certifier 1 ✓ Certifying Physician: To	the best of my knowledge,	, death occurred at the ti	me, date and place, a	and due to the cause	e(s) and manner as	stated.
	8 Fur	Medicai	(Check only 2 Medical Examinar: On the						
	To th To th	Me	29b. Signature and title of certifier		29c. Licen:	se number	29d.	Date signed (Month	n, Day, Year)
			I Storm	DOCTOR	ρ	18916	/	VOY 01	, 2005
	21.1		30. Name and address of person who completed ca	use of death (Item 23a) (Tyne Print)		_		/
	811		ISMAILA JIBRIN,	ST. AGN	IES HOS	PITAL,	BALTI	MORE 1	ND 21229
7		ate	31. Date filed (Month, Day, Year)	Registrar's Signature	hacks				
	Regist	rar	NOV 0 4 2005	Blue St /					
DH	MH 17 Rev 1/2	2001	•	-	100111				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Registrar

2005

CTOBER

MARY ELLEN PUNTE

ORIGINAL

			For State Registrar	State of M	Maryland / Dep Ce	artment of H			giene 005	35712
	Physici	an	Decedent's Name (First, Middle Kathryn	e, Last)		Piersor	1	2. Date of Dea Month Novembe	Day Year	3. Time of Death 2:55 P M
	/Medic Examin		4a. Facility Name (If not institution		er)	4b. City, Town, or			4c. County of Dea	
	LAdillii	CI	Genesis Elderca	re- Heritag	e Center	Dundalk			Baltimor	e
	Funeral Director		5. Social Security Number 518-18-8188 Usual Residence of Decedent	6. Sex 7. / 1 ☐ M 2 🔀 F	Age (In yrs. last birthday 86 Yrs.	Months Days	If Under 24 Hours M	Hrs. 8. Date of Birth (Month, Oay May 26,	^{9. Bir} 1919 Sou	thplace (State or Foreign ountry) ith Dakota
	yland		10a. State 10b. County		10c. City, Town or I					10d. Inside City Limits
	8e-f sl	Director	MD Balti	more	Dunda.					1 ☐ Yes 2X No
	h with th		10e. Street and Number 1904 Madison Ro	ad		10f. Zip Code 2122	22		10g. Citizen of What C USA	ountry?
' O	within 72 hours after death with the Maryland ene. than "naturel", or Items 23e or 28e-f show the Marical Examiner must be notified at	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Deceder Armed Force 1 Tyes 20 If Yes, Give	nt Ever in U.S. 13 s?] No			(Specify Yes or No- uerto Rican, etc.)	14. Race - Am Black, Whi	
0036	urel', o	2	3X Widowed 4 ☐ Divorced	Year or Dates	S:	1 ☐ Yes Ž O ŽNo	Specify:			ite
21215-0036	thin 72 ho e. an "natu Medical	Completed	15. Deceden (Specify only highe Elementary/Secondary (0-12)	t's Education st grade completed) College (1-4c)	(Giv life.	edent's Usual Occup e kind of work done o DO NOT use retired	ation during most of i d)	working	16b. Kind of Business	Vindustry
N	D D -		9 years 17. Father's Name (First, Middle,	(act)	Но	usewife	19 Mothor's N	Name (First, Middle,	Own Home	
Maryland	d o d o	To Be	Amil Gottschalk					Gottschal		
Aary	d 2 should it and Men 7 is marke traumatic		19a. Informant's Name/Relations			•			r, City or Town, State,	Zip Code)
	1 an Heali em 2		Shirley Sites 20a. Method of Disposition	Daughte		GOUGN SEI position (Name of ematory or other place	- 1	altimore,_ vember	20c. Location - City or	r Town, State
Baltimore,	Pages nent of ant: If it ury or o		1 XBurial 2 ☐ Cremation 1 4 ☐ Donation 5 ☐ Other (S		(e) _	n Cemetery	1 - 1 -		Dundalk, MI).
Balt	permit. Pages Department of Important: If i any Injury or once.		21. Signature of Funeral/Service	Licensee OM		22 Name and Addre Connelly 1 7110 Solle	sof Facility ers Poin	Home Of D nt Road, D	Dundalk,P.A Dundalk,MD.	21222
	v		23a. Part1. Enter the disease of shock, or heart failure. Uist	complications that caus only one cause on each	sed the death Do not en					Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. COR	ONAR	AKT	TER)	1 777	EASE	157EARS
	Examiner		Sequentially list conditions	ESSI	as a consequence of).	LHY	PERT	TENS	Nois	26 YEARS
X	ted sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequence of):		•	•		
0	death certificate be executed e attending physician and bd for use as the burial-transit		that initiated events resulting in death) Last	C Due to (or	as a consequence of):					
68760,	physicist the but	dlcal		d						
Вох 6	leath certific attending p	an/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor		☐Ectopic pregnancy	,		23d. Date of de	
.O. B	that the deal	Physiclan/Med	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		at time of death 5	Other (specify)			Month	Day Year
Δ.	26 Dec	by Ph	Part II. Other significant conditi	ons contributing to death	n but not resulting in the	underlying cause giv	en in Part I.		bacco use contribute t	
Records,	w require been si should t	eted						24a. Was a	24h Were a	robably 4 Unknown utopsy findings available
Rec	The lav ate has page 2	Completed						autops pertor	sy prior to death? 2 No 1 □ Ye	completion of cause of
Vital	Phyaician: Th this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital:		Oth	00	Death (Check only or		
of	Phys this ral di	To To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpa 28a. Date of I		of 28c. Injur	4 Nursin		ence 6 Other (Speow injury occurred	ecify)
sion	or Attending Phater death. Director: After thin by the funeral	catlo	1 Matural 5 ☐ Pendii 2 ☐ Accident investi 3 ☐ Suicide 6 ☐ Could	gation	Day Year) Injury		Yes 2 □ No			
Division	or Attent after death Director:	Certification;	3 Suicide 6 Could 4 Homicide determ	alace of	Injury - At home, farm, s etc. (Specify)	street, factory, office		28f. Location (S City or Tow	itreet and Number or F n, State)	tural Route Number,
_	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical C	29a. Certifier 1 Certifyin (Check only one) 1 Medical	ng Physician: To the be Examiner: On the basis and manner	s of examination and/or	ath occurred at the tir investigation, in my o	ne, date and pla pinion, death o	ace, and due to the cocurred at the time, d	ause(s) and manner a date and place, and du	s stated. e to the cause(s)
)	To the within To the compl	Me	29b. Signature and time of certific	Fingh	M.D.	29c. Licens	e number	10 1	29d. Date signed (Mon	
	X		30 Name and address of person	w Scompole Course	of death (I) m 23a Type	9. Bring 1 0 - 1	ARIT	CHIET	+ IGHWA	T BALTIMORE
	Sta Regist		31. Date filed (Month, Day, Year, NOV 0 4		strar's Signature	who a	- 1 - 1 - 1 - d =			

DHMH 17 Rev 1/2001

ORIGINAL

		•	For State Registrar	State of Maryland / Depa	artment of Health and I	Mental Hygier	211115	35713
	Physici	an	Decedent's Name (First, Middle, Last,			2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death		1, 2005 4c. County of Death	7237 M
		Ŭ.	12011 -	ours Hospital	Baltimor If Under 1 Year If Under 24 Hrs.	_	NA	
	Funeral Director		5. Social Security Number 6. Se 15 - 34 - 8/17	7. Age (In yrs. last birthday) M 2 F 66 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye)	938 M	olace (State or Foreign ntry)
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
	e Mary	Director	Maryland N/A	Balt	imore			1 Yes 2 No
	with th		25/2 Fyotoc	- Hall Avo	10f. Zip Code	10g.	Citizen of What Coul	ntry?
	r death	Funerai	11. Marital Status	Armed Forces?	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - Americ Black, White,	
036	J within 72 hours after death with the Maryland Jiene. I then "netural", or Items 23s or 28s-f show The Mulical Examerer must be indiffied at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 M No If Yes, Give Year or Dates:	1 ☐ Yes 2 🗖 No Specify:		Specify: P	ack
21215-0036	within 72 ho ene. than "netur	leted	15. Decedent's Edu (Specify only highest grad	le completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	king 16b.	. Kind of Business/In	dustry
	filed withi Hygiene. Ather than ant, the M	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	hotographe	C S	elf-en	played
Maryland	be od o	To Be	17. Father's Name (First, Middle, Last)	hours	18. Mother's Nam	ne (First, Middle, Maid	en Sumame)	1
lary	2 should be and Menta Is marked eumatic ev	F	19a. Informant's Name/Relationship (T)	(po, Print) acus ter 196. Mailin	ng Address (Street and Number or Ru	ral,Route Number, Cit	y or Town, State, Zi,	Code)
	is 1 and 2 should of Health and Meritem 27 Is marke other treumatic		VITS · Lenobla 20a. Method of Disposition	Walker 450 20b. Place of Dispo	sition (Name of natory or other place)	Date 20c.	Location - City or To	own, State
Baltimore ,	Page nent o ant: If ury or		1 ⊠ Burial 2 □ Cremation 3 □ F 1 □ Donation 5 □ Other (Specify)	demoval from State Arbutus	5 Mem. Park 1171	2005 A	rbutu	s.Md.
Ball	permit. Pag Department Importent: I any Injury o once.		21. Signature of Funeral Service Licens	Russ Ja	2. Name and Address of Facility OSEPH L RUSS OSEPH AVE	Funeral,	Home, P.	A.
F			shock, or heart falliure. List only o	lications that caused the death. Do not entone cause on each line.	er the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	Sepsis			
	Examiner	16	Sequentially list conditions, if any, leading to immediate	b				
	cuted nd ransit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	c				
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical Ex	resulting in death) Last	Due to (or as a consequence of):				
9	ing phy:	Medic	IF FEMALE:					
Вох	death certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of deliver	ery Day Year
P.O.	that the de ad by the detached	Phys	9 Unknown	9☐ Unknown ntributing to death but not resulting in the ur	adad in a sana in Bad I	22a Did tabasa	to use contribute to t	ha equipa of double?
ecords,	quires ti n signe uld be c	ed by	Fait II. Ottos significant conditions co	ithouting to death out not resulting in the di	ndenying cause given in Part I.	1 Tes	,	pably 4 Unknown
leco	e law requ has been le 2 shoul	Completed				24a. Was an autopsy	prior to co	opsy findings available impletion of cause of
Vital R		O	25. Was case referred to medical		26 Place of Dea	performed' 1 Yes 2 1 th (Check only one)		2 No
of Vi	Physicien: this certific ral director,	To B	1 195 2 2 140	Hospital: 1 Ampatient 2 ER/Outpatien	nt 3 DOA Other: 4 Nursing H	ome 5 Residence		(y)
ion		atlon:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury	f 28c. Injury at Work? M 1 Tyes 2 No	28d. Describe how in	jury occurred	
Division	of or Attending after death. Director: A d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, stribuilding, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, St.		al Route Number,
J	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical Ce	29a. Certifier 1 Certifying Phy	sician: To the best of my knowledge, death iner: On the basis of examination and/or inv				stated.
	o the F ithin 24 o the F omplete	Medi	one) 29b. Signature and title of certifier	and manner stated.	29c. License number	29d. (Date signed (Month,	Day, Year)
	- s - ō		· Lallford	CANT, MD	D0052950	' 1	buchber	2, 2005
	3		30. Name and address of person who c	ompleted cause of death (Item 23a) (Type,	Print) Ba House, MD	21223	,	
	Sta Registi		31. Date filed (Month, Day, Year) NOV 0 4 200	32 Registrar's Signature	de)			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month Year 11 01 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kingsville Under 1 Year If Under 24 Hrs. 12353 Philadelphia Road Baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1□M 2√F Months Hours Director 82 11/13/1922 139-14-9163 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland nent of Heath and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28e-f show any or other treamatic event. Ite Medical Estriper man be notified at any or other treamatic event. Ite Medical Estriper man be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√2 No by Funeral Director Kingsville Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12353 Philadelphia Road U.S.A. 21087 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ≥ 2 ▼No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaking Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Leonard Earl Dewitt Sarah Ruth Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry J. Pence (husband) 12353 Fhiladelphia Road - Kingsville, MD 21087 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ∑Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Importent: If any njury or ance. Gardens of Faith Cem. 11/04/2005 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. D 11750 Belair Road - Kingsville, Maryland do 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician uars disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** ente Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequ resulting in death) Last nce of): P.O. Box 68760, attending physician for use as the buria Physician/Medicai the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 5 Other (specify) detached 9 Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobasco use contribute to the cause of death? Division of Vital Records. þ 1 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 1 ☐ Yes 2 ☐ No 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, 1 Yes 2 No Other: 4 Nursing Home 1 Inpatient Jo 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medicai (Check only one) and manner stated 29b. Signature and tyfle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) White marsh

Registrar

State

31. Date filed (Month, Day, Year)

NOV 0 4

Q

32. Registrar's Signature

			For State Registrar	State of Ma	ryland / Depa	artment of I			giene Reg. N2 (005	35715
- 10 10			Decedent's Name (First, Middle, Las	t)				2. Date of De	ath		3. Time of Death
10	Physici /Medic	_	Junior R	Loyster				Month	3/	200S	- 19:10 PM
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of I	Death	4c. Co	unty of Death	ו
	W. W.		Union Memorial				Baltim			NA	
	Funeral Director		5. Social Security Number 6. Se 240–48–0606	ox 7. Age → M 2□F	(In yrs. last birthday) 7.1 Yrs.	If Under 1 Year Months Days		Min. (Month, Da	y, Year)	9. Birth	nplace (State or Foreign untry)
- 1		3	Usual Residence of Decedent	^	74 Yrs.			8-28	-31		N.C.
	how		10a. State 10b. County		10c. City, Town or Lo	ocation	_				10d. Inside City Limits
	e Ma	cto	Md. NA		Ba.	ltimore					1x Yes 2□No
	or 28	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Co	untry?
	s 23s	ra	2401 A Greenmou			212]			US.		
	ltsm Itsm	Funeral Director	11. Marital Status 1 Never Married Married	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of F If Yes, specify Cub	Hispanic Origin an, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)	- 14.	Race - Amer Black, White	
39	urs af	by	3 Widowed 4 Divorced	1 TY Yes 2 □ No If Ye s, Give Year or Dates:		1□Yes 2∏XNo	Specify:		Sp	ecity: Bla	ck
21215-0036	within 72 hours after death with the Maryland ene. than "netural", or items 23a or 28a-f show the Madical Exertiner rount by mailing at	Completed	15. Decedent's Ed (Specify only highest grad	ucation	16a. Dece	dent's Usual Occup	pation	f warling	16b. Kind	of Business/I	ndustry
2	ithin	nple	Elementary/Secondary (0-12)	College (1-4or 5+	·)	kind of work done DO NOT use retire	d)	Working			
7	ygier her th		11th grade		L	aborer					Operator
Maryland	tai H d otl	Be	17. Father's Name (First, Middle, Last) Cory		Royster			: Name <i>(First, Middle,</i> B ertha	Maiden Sui	mame) Mitc	holl
Š	d Me mark matic	은	19a. Informant's Name/Relationship (7	vne Print)		ng Address (Street		or Rural Route Number	er City or To		
<u>⊠</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show amy nurry or other traumatic event, the Marolcal Extendings on the nutilised at another.		Donald Lee Royste					Baltimor			
re,	f Head		20a. Method of Disposition		20b. Place of Dispo	sition (Name of matory or other pla		Date		ion - City or 1	
altimore,	Page nent c int: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Greenmou			11-3-05	Balt	imore,	Md.
alti	mit.		21. Signature of Funeral Service Licen:	Α.		2. Name and Addre			imore		21202
—	20E # 9		Forment M Th	oupen &	1	March F.H	I. East	1101 E			
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	one cause on each line	3.				rrest,		Approximate Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition resulting in death)	a. End	Stage &	Penal,	Disea	se			40 years
	/Medical Examiner		resulting in dealin)	Due to (or as a	Stage k consequence of): He M	011:4					11
п		0	Sequentially list conditions, if any, leading to immediate		consequence of):	ellitus			_		70 years
1	uted d ansit	Examiner	Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Hine	tencio	n					40 years
ó	exec en an rial-tr		resulting in death) Last	Due t as a	consequence of):						
8760,	death certificate be executed e attending physicien and id for use as the burial-transit	Physiclan/Medical		d							
9	ig p	Med	IF FEMALE:								
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o	Fetal death 3	Ectopic pregnanc	у		23d.	Date of deliver Month	very Day Year
P.0.	that the death cer ed by the attendin detached for use	ysic	1 Yes 2 No	4□Pregnant at t 9□Unknown	me or death 5L	Other (specify)					,
	law requires that the as been signed by th 2 should be detache	y Ph	Part II. Other significant conditions co	intributing to death but	not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did t	obacco use	contribute to	the cause of death?
Vital Records,	w requires that been signed b should be det	ed by					_	1`	∕es 2□N	o 3 Pro	bably 4 Unknown
000	aw recast bee	Completed						24a. Was	an 2	4b. Were aut	opsy findings available
Ä	The lavate has	mo						autor perfo	rmed?	death?	ompletion of cause of
ita	ysician: The is certificate had director, page	Bec	25. Was case referred to medical examiner?				26. Place of	Death (Check only of			
of <	Physic this ce al dire	은	1 ☐ Yes 2 No	Hospital: 1 Nnpatien		IL JU DON		ng Home 5□ Resid	dence 6 🗆	Other (Spec	ify)
D U	Attending Physician: r death. sctor: After this certifici by the funeral director, i	inol :	27. Manner of Death Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	Wo		28d. Describe I	now injury oc	curred	
isio	death death stor:	Icat	2 Accident investigation 3 Suicide 6 Could not be	290 Place of Injur	y - At home, farm, str		Yes 2 □ No		Stead and M	umbas as Ou	al Route Number,
Division	after Dirse	Certification:	4 Homicide determined	building, etc.	(Specify)	eet, factory, office		City or Tox	vn, State)	umber or rial	ai noble Number,
	e Hospital or Attenc 24 hours after death 8 Funerel Director: etely filled in by the i		29a. Certifier Certifying Phy	sician: To the best of	my knowledge, deat	occurred at the til	me, date and p	place, and due to the	cause(s) and	manner as	stated.
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Exam	iner: On the basis of e and manner stat	examination and/or in	vestigation, in my o	opinion, death	occurred at the time,	date and pla	ce, and due	to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier			29c. Licens	se number		29d. Date si	gned (Month	Day, Year)
•	4		- My la	'yy	M.D.		4389	46	Oct	.31,	2005
	4		30. Name and address of person who of	4	ath (Item 23a) (Type,	Print)	0	Harita) u	. a.	
	Sta	te.	31. Date filed (Month, Day, Year)	32. Registrar	Union 's Signature	- icms	nac	1 rspi lau	, ,	, ,	
1	Registr		NOV 0 4 2		JA A	make					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 10 AM /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore of Mayland Medical Unter Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months Days 1**∑**M 2□ F 20 Hours Min. Director 226-37-3673 24,1985 VA Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Extrapret must be notified at 10d. Inside City Limits VA Fairfax Alexandria 1 ☐ Yes 2 X No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5907 Reservoir Hts. Ave. 22311 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Student University . Pages 1 and 2 should be filed w tment of Health and Mental Hygie tant: if item 27 is marked other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ronald Jack Rogers Shane Teichler Rogers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shane T. Rogers/Mother 5907 Reservoir Hts. Ave. Alexandria, VA22311 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Fairfax Memorial Park 1 XBurial 2 □Cremation 3 □Removal from State 4 □Donation 5 □Other (Specify) permit. Page Department o Important: if any injury or once. 11/03/05 Fairfax, VA 21. Signature of Fundral Service-Licensee 22. Name and Address of Facility Fairfax Memorial 9902 Braddock Rd. Fairfax, 22032 amon 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Coaquioparni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit Due to (or as a consequence of) Certification: To Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probebly 4 Unknown peen Resal Fulure 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No this certificate 1 Tes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 EN/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work?

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 ours after death. lerel Director: After this certific filled in by the funeral director, within 24 hours a

Medical

State

Registrar

1 Natural

3 Suicide

29a. Certifier

4 Homicide

5 Pending investigation 6 ☐ Could not be

29/05

and manner stated

SSIAM Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 No

28d. Describe how injury occurred DRIVER OF

(AL WMICH STRUK UTILITY POLE

IN A (AR ACCIDENT

28f. Location (Street and Number or Rural Route Number,
City or Town, State) 10500 BLOCK OF

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

AU4176435616535

29c. License number

29d. Date signed (Month, Day, Year) oct. 29, 2005

no completed cause of death (Item 23a) (Type, Print)

Felix Lui 31. Date filed (Month, Day, Year)

NOV 0 4 2005

arene Street, Baltimore 32. Registrar's Signature

/Medic	an	1. Decedent's Name (First, Middle, Thomas I. Ry						Mon	of Death D	ay Year 01 2005	3. Time of Death 1:11 PM
Examin		4a. Facility Name (If not institution,	give street and number)		4b. Cit	ty, Town, or Lo	ocation of De	ath	4	c. County of Deat	h
. 4	j. A	225 Linton Run R		- /t t t ! . d		ort Dep	osit	rs 0 D	- (Dist	Cecil	
Funeral Director		5. Social Security Number 213-52-8074	5. Sex 7. Ag 12XM 2□ F 4	e (In yrs. last birtl 1			Hours M	n. (Mor	of Birth oth, Day, Year 13, 1	7) 9. Birt. Co	hplace (State or Foreign untry) :vland
JII ECTOI		Usual Residence of Decedent						INOV.	10, 1	.903 Mai	
how		10a. State 10b. County	1	10c. City, Town		D					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
Ba-f o	Director	Md. Ceci	<u> </u>			Deposi	<u>. </u>		1.0		
23a or 28a-f ehow ust be notified at	ă	10e. Street and Number 255 Linton R	um Dood		10f. 2	Zip Code	904			C. A	ountry?
na 23	Funeral	11, Marital Status	12. Was Decedent	Ever in U.S.	13. Was Dec	cedent of Hisp pecify Cuban,		(Specify Yes		S.A.	
ef, or iter	þ	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? d 1 Yes 2 h If Yes, Give Year or Dates:	No		pecify Cuban, l 2 ☑ No		erto Rican, e	tc.)	Black, White Specify: wh	_
"nature!", idical Exc	ted	15. Decedent's (Specify only highest	Education	16a.	Decedent's Us (Give kind of v	sual Occupation	on ring most of v	varkina	16b.	Kind of Business/	Industry
en .	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)	(Give kind of v life. DO NOT	use retired)			aut	omotive	parts
ital Hygiene. id other then "natur event, the Medical	S	12 years 17. Father's Name (First, Middle, La	act)		owner	1.5	8 Mother's N	ame (First)	Middle, Maide		
ed of	Be	Thomas I. Ry						Balda		in Sumame)	
nark mark	၉	19a. Informant's Name/Relationship		19b.	Mailing Addre	ess (Street and				or Town, State, Z	Zip Code)
alth ar 27 is r trau		Fred Rynes/b	rother	2	04 Mel:	issa Wa	ay, Fo	rest H	i11, M	d. 21050	
Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "n eny findury or other fraumatic event, the Mast once.		20a. Method of Disposition		20b. Place of cemeters	Disposition (N	lame of r other place)		Date	20c. t	Location - City or	Town, State
ant: if		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		Highvi	ew Mem	. Gdns.	. 11	/5/200	5 Fa	llston,	Md.
oparti nport ny inj nce.		21. Signature of Funeral Service Li	censee	1	22 Name Schir	and Address of	of Facility Funera	1 Home	of Be	1 Air, I	inc.
0 5 • d		· /cu	ny		610 1	W. MacI	Phail :	Road.	Bel Ai	r, Md. 2	1014
ysician		shock, or heart failure. List or Immediate Cause (Final disease or condition	nly one cause on each lin	Arrhyth		ode of dying, s	such as card	ac or respira	tory arrest,		Approximate Interval Between Onset and Death
Medical aminer	cai Examiner	shock, or heart failure. List or Immediate Cause (Final	a. Cardiac Due to (or as Due to (or as C.	Arrhyth a consequence o	mia of): ensive of):	ode of dying, s	such as card	ac or respira	tory arrest,		Interval Between
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 0415 AM Keinhardt Kose 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 100000r 5. Social Security Number TIMORE If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) If Under 1 Year Funeral Birthplace (State or Foreign Country) 1□M 2**A**F 218-03-6792 Days Months Director BALTIMORE MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is markad other then "neturel", or items 23e or 28a-f shor traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 No DALTIMORE DALTMORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2123 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married "neturel", or Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) and Mental 2 llian Stockman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 54041 TVNORE, MD2123

20c. Location - City or Town, State aumond 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 5 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Department of Important: If any injury or = 5 Bel Air Memorial Gardens 22. Name and address of Facility RE, MD ZIZ34. 21. Signature of Funeral Service Lice EVAIDS FUNERAL CHAPEL, 8800 HARFORD RA r complicer in sithat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tonly one luse on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably þ Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Tes 2L No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 1 Inpatient 4 Nursing Home 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) -17041 D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YORK RUAY #38 LUTHERVILLE MY 21093 MARC I. COAVEY an 1205 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Rose

DHMH 16 Rev 6/95

			1 - For Stata Ragistrar	State of Mar		partment of ertificate o			liene og. No. 2005 (35719
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	-zauska	3.5	· · · · · · ·		2. Date of Dear Month	Day Year	3. Time of Death
)	Examir Funeral		5. Social Security Number 6. Sex	Crkway Nu	rsen Fal (In yrs. last birthd 80 Yrs	ay) #Under 1 Yes		LL 8. Date of Birth	Country)	
	Director 4 ahow	or	Usual Residence of Decedent 10a. State 10b. County Maryland N/A	1	10c. City, Town on	Location		07/20/	10d.	Inside City Limits 1 Yes 2 No
	3a or 28a-	Direc	10e. Street and Number 1627 Eastern Avenu		Darcinoi	10f. Zip Code	•		Og. Citizen of What Country? Jnited States	?
9036	be filed within 72 hours after death with the Maryland that Hyglene. Id other than "natural", or Itams 23a or 28a-f ahow avant, itte Medical Excention in the Indifficed at	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 □ Yes 2 M No If Yes, Give Year or Dates:			f Hispanic Origin? (Suban, Mexican, Puel lo <i>Specify:</i>		14. Race - American Black, White, etc. Specify: White	
121215-0036	filed within 72 P Hygiene. othar than "natu ant, Itte Mydica	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5+)	(G lif	cedent's Usual Occ ive kind of work dor e. DO NOT use reti retary	ne during most of wo	nrking	City Schools	ry
Maryland	d 2 should be fi th and Mental H 7 Is markad of traumatic avar	To Be	17. Father's Name (First, Middle, Last) Floryan Rybczynski 19a. Informant's Name/Relationship (Ty		19b. M	ailing Address (Stre	Bertha	me (First, Middle, I Aleksandı ural Route Number		de)
	es 1 and 2 of Health a if itam 27 is or othar tra		Janice Kachadourir 20a Method of Disposition 1 Burial 2 Cremation 3 DR		20b. Place of Di cemetery, o	sposition (Name of crematory or other p	elace)	Date	ore, MD 21239 20c. Location - City or Town,	
Baltimore,	permit. Pag Department Important: l any injury o		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensity	" Webe		Cremator 22. Name and Add Dayid J 401 S. Ch	ress of Facility		Baltimore, Mar es P.A. Imore, Marylar	
	Pnysician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	tastaticonsequence of):	227	ying, such as cardia	•	Int	proximate erval Between uset and Death
8760,	rate be executed whysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a o	consequence of):					
.O. Box 6	death certific e attending p id for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death	3 □Ectopic pregnar 5 □ Other (specify)	ncy		23d. Date of delivery Month Day	y Year
ords, P	uires tha signed d be de	by	Part II. Other significant conditions con	stributing to death but	not resulting in the	underlying cause	given in Part I.	23e. Did tob	pacco use contribute to the cases 2 No 3 Probably	1
al Records,	The law ate has b page 2 s	Completed						24a. Was a autops perform	y prior to comple ged? death?	findings available ation of cause of
	Phyaic this ceral direct	tion: To Be	27. Manner of D ath	1 Inpatient 28a. Date of Injury (Month, Day)	28b. Time	of 28c. In	Other: 4 Nursing I		nnce 6 Other (Specify) w injury occurred	
Division	spital or Attanding ours after death. haral Diractor: After filled in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	r - At home, farm, (Specify)			28f. Location (St. City or Town	reet and Number or Rural Ro r, State)	ute Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	edicai	one) 72 Medical Examil	sician: To the best of a ner: On the basis of ea and manner state	xamination and/or	investigation, in my	opinion, death occu	e, and due to the caurred at the time, da	uuse(s) and manner as stated ate and place, and due to the	1. cause(s)
	To To To To To To To To To To To To To T	M	29b. Signature and title of conflier)	Some Some	29c. Lice	nse number) 059 4 23	25	3d. Date signed (Month, Day,	Year)
=	8		30. N. e and addr ss of person who	pleted cause of dea	th (Item 23a) (Typ	Hospital P	rof Brule	love #32	Ovember Z Zo	MD
	Sta Registi		31. Date filed (Month, Day, Year)	Registrar's	s Signature	ester.			,	21239

NOVEMBER 2.

			1 - For State Registrar	tate of Marylar		artmen rtificate			ınd Me		giene	005	3572	L
	Physici /Medic	_	Decedent's Name (First, Middle, Last) Ronald Thomas	Rohrs					2	2. Date of Dea Month Novembe	er 2	. 2005	3. Time of Death 6:50 p.	
No.	Examin		4a. Facility Name (If not institution, give stree 315 Southeastern Te			4b. City, Ess		Location of			4c. (County of Dea		
	Funeral Director		5. Social Security Number 6. Sex 1212-62-7085	2□ F 7. Age (In yrs. 51	last birthday) Yrs.	If Under Months		If Under 2 Hours	Min.	B. Date of Birtl (Month, Day EB 4	Year) 1954	9. Bi	rthplace (State or Fore country) MD	ign
	faryland ehow	or	Usual Residence of Decedent 10a. State MD Baltimore		ty, Town or Lo	cation							10d. Inside City Limi	
	or 28a-1	Director	10e. Street and Number		iyacs	10f. Zip	Code				10g. Citiz	en of What C		
	ath w	rai	12408 Regwood Road				.082				USA	4		
980	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23e or 28e-f ehow other traumatic event, if a Medical Evar, instruent terrorilliad at	by Funeral	1 Never Married 2 Married	Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	'	Was Deced f Yes, spec 1 ☐ Yes 2		spanic Orig n, Mexican, Specify:	gin? (Spec , Puerto Ri	ify Yes or No- ican, etc.}		4. Race - Am Black, Wh Specify: W		
21215-0036	vithin 72 ho ne. hen "natu s Medical	Completed by	15. Decedent's Educati (Specify only highest grade co Elementary/Secondary (0-12)	on <i>mpleted)</i> College (1-4or 5+)	16a. Deced (Give life. I	kind of wor DO NOT us	rk done d se retired	lurina most	of working	7		d of Business		
	lled v Hygie ther t		17. Father's Name (First, Middle, Last)		DIOCK	. WOLK	er	18 Mother	r'c Namo /	First, Middle,		struct	tion	
Maryland	nould be f d Mental F narked of natic eve	To Be	Anthony Rohrs	Drive)	101 11 11		(2)	Dolo	res	Smitz	zel			
	and 2 sh salth and n 27 is n		19a. Informant's Name/Relationship (<i>Type</i> , Rachel Schuman – dau	ıghter	12408	Regw	700d	Road,		Aoute Numbe	r, City or 210		Zip Code)	
Baltimore,	permit. Pages 1 an Department of Heal important: if item 2 eny injury or other ance.		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Rem- 4 ☐ Donation 5 ☐ Other (Specify)		Place of Dispo cemetery, cren esapeake				.1/5/2			sation - City o ${ m svill}$	r Town, State	
Balti	permit. Departn imports eny inju		21. Signature of Funeral Service Licensee	MO14		Name an	d Addres	s of Facility	Lol	ormann Drive	PA Tow	zson. N	1D 21286	
	Physician /Medical		23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one of the disease or condition resulting in death) a	ons that caused the dea ause on each line. Athoro Due to (or as a conse	sekreti	er the mode	e of dying	g, such as o	cardiac or	diseas	rest,		Approximate Interval Between Onset and Death	
8760,	certificate be executed unding physicien and use as the burial-transit	icai Examiner	Soquer tially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec										
P.O. Box 687	certific ading p	Physician/Medic	in the past 12 months?	If yes, outcome of pregn 1 □Live birth 2 □ Fet 4 □ Pregnant at time of (9 □ Unknown	al déath 3	Ectopic pro			-		2:	3d. Date of de Month	blivery Day Year	
	law requires that the death as been signed by the etter 2 should be detached for u	ρχ	Part II. Other significant conditions contrib	uting to death but not re	sulting in the u	nderlying ca	ause give	en in Part I.			bacco us		to the cause of death?	٧n
I Records,	The ate h page	Completed							_	24a. Was a autop perfor	sv	24b. Were a prior to death?		ek h
/ita	ilcian: Th certificate rector, pag	Be (25. Was case referred to medical examiner?					26. Place	of Death	Check only or	1			
ion of Vital	는 는 등	ation: To	1X Yes 2 No Hosp 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	oltal: 1 ☐ Inpatient 2 ☐ 18a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury		8c. Injury Work	4 🗀 Nur	28	e 5 Resid			_{ecify)} At scen	e
Division	al or Atte s efter de i Directo id in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	8e. Place of Injury - At h building, etc. (Speci	ome, farm, str	eet, factory	, office		28	If. Location (S City or Tow	treet and n, State)	Number or F	Rural Route Number,	
	To the Hospital or Attending Is within 24 hours efter death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier 1 Certifying Physicia (Check only one) 25 Medical Examiner:	on: To the best of my kin On the basis of examinand manner stated.	owledge Jeat ation and/or in	occurred vestigation,	at the tim in my op	date and pinion, deat	placa, an	d dua to the e I at the time, o	susu(s) s late and p	and interiner a place, and du	s stated. e to the cause(s)	
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	7	(i)	Pamela E. Southal	leted cause of death (Ite			1 Pe	nn St	reet	Balti	more	, Mary	riand ZIZOI	
46	Sta Registi	1/	31. Date filed (Month, Day, Year) NOV 0 4 2005	A. Registrar's Sign	ature	W								

		1 - State Registrar		aryland / Dep	ertificate of			eg. N2 0 (05 357
Dhuaiai		1. Decedent's Name (First, Middle,	Last)				2. Date of Deat Month	h Day	3. Time of D
Physicia Medic/		Omagene Rap	oolti				November	2 2 2	005 6:05 a
Examin		4a. Fecility Name (If not institution, g				or Location of Death		4c. County	
	1	Gilchrist Center			Towson				imore
uneral irector			5. Sex 7. Ag 1 ☐ M 2 💢 F	ge (In yrs. last birthda 82 Yrs.	y) If Under 1 Year Months Days	II Under 24 Hrs. Hours Min.	B. Date of Birth (Month, Day, MAY 16	Year)	Birthplace (State or Country)
ctor		193-14-6794 Usual Residence of Decedent		02 113.			MAY 16	1923	PA
4		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City
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-	Irec	10e. Street and Number		1.1	10f. Zip Code		10	0g. Citizen of	Whal Country?
	aiD	11525 Sherwood	Road		2115	56		U	SA
	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	3. Was Decedent of H	Hispanic Origin? (Spean, Mexican, Puerto	ecity Yes or No- Rican, etc.)		ce - American Indian, ck, White, etc.
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		17. Father's Name (First, Middle, La	ıst)			18. Mother's Name	(First, Middle, N		
	To Be	Samuel Franc	cis			Ethel	Living	ston	,
	-	19a. Informant's Name/Relationship	1 21 .	19b. Ma	iling Address (Street	and Number or Rura	I Route Number,	City or Town,	State, Zip Code)
once.		Donna Schimunel	k - daughte		25 Sherwoo	1000			
		20a. Method of Disposition 1 □ Burial 2 X Cremation 3	B □Removal from State		position (Name of rematory or other place	CB)		20c. Location -	- City or Town, State
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ouce.		21. Signature of Funeral Service Lie	censee —	MO1//2	22. Name and Addre	ohen D. Lo	hrmann.	РΑ	
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ın		Immediate Cause (Final			- (1)				Interval Betw
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/Medi Exami		4a. Facility Name (If not institution, given	ve street and number)		4b. City, Town, o	or Location of Death	JODGEL	4c. County	
5	\mathcal{E}_{i}	202 Duke of Yor				sville		Baltin	
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and wo		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	or Location				10d. Inside City Limits
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Aary 2 sho		19a. Informant's Name/Relationship			lailing Address (Street				
		Mrs. Hilda Ruby,	Mother	203	Duke of You	ork #104,	Cockeysy	ille, l	MD 21030 City or Town, State
nor of larges ages ont of larges y or o		1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci		cemetery,	crematory or other planalley Memoria	ce)			
Baltimore, permit. Pages 1 ar Important: If Item any Injury or other		21. Signature of Funeral Service Lice	**	Dilitary V					maryland eral Services of
Balt permit. Departi		1 Stt	M01113			ley, P.A. nia Road, Tim			
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Vision of Vital Records, P.O. Box 687 Attending Physician: The law requires that the death certificate or death. •ctor: Atter this certificate has been signed by the attending physby the funeral director, page 2 should be detached for use as the	<u>م</u>	Part II. Other significant conditions	contributing to death bu	t not resulting in th	e underlying cause giv	ren in Part I.			bute to the cause of death? 3 Probably 4 Munknown
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Divital or vital or vital or vital or vital Dire	Certification:	4 D Nothicide	building, etc.	. (Specity)			City or Town,	State)	
Division of Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medicai	29a. Certifier 1 Certifying Pt (Check only one) 2X Medical Example 1	nysician: To the best of miner: On the basis of and manner stat	examination and/o	eath occurred at the tir or investigation, in my o	me, date and place, a ppinion, death occurre	nd due to the cau d at the time, dat	use(s) and man le and place, ar	ner as stated. nd due to the cause(s)
To th Within To th compl	Me	29b. Signature and title of certifier			29c. Licens		290	d. Date signed	(Month, Day, Year)
		Messe			OCI	ME	0	ctober,	25, 2005
		30. Name and address of person who	completed cause of de	eath (Item 23a) (Ty	pe, Print) 111 Pe	enn Street	Baltin	nore, Ma	aryland 21201
Sta		31. Date filed (Month, Day, Year)	32. Registra	_					
Regist	ar	NOV 0 4 2005	Acres .	K L	all s				

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	Physici	ian	Decedent's Name (First, Middle, La	•							2. Date of D	eath Da	iy	Year	3. Time of I	_
	/Medi		Catherine Elizabeth								Oct.	31	, 2	<u>005</u>	194	<u>3 m</u>
	Examir	ıer	4a. Facility Name (If not institution, giv Union Memorial Hospit						Location	of Death		4c	. County o			
					//=	5-11:41		altim	-	04 14-0			N/A			
н	Funeral		5. Social Security Number 6. S 045-14-1735	ex □ M 2DXF / 8		last birthday) Yrs.	Months	1 Year Days	If Under Hours	Min.	8. Date of B	irth Jay, Year	22	9. Birthpla	ace (State or York	Foreign
	Director		Usual Residence of Decedent			110.					Aprili	.1, 13	22	New	fork	
	/land		10a. State 10b. County		10c. Cit	y, Town or Lo	cation		•					10	d. Inside City	y Limits
	Man If sh	ţ	Tennessee Shelby		M	lillingto	on								1 ☐ Yes	27 No
	r 288	Director	10e. Street and Number				10f. Zip	Code			 	10g. Cit	tizen of W	hat Count	ry?	
	h wit	0	7231 Renda Street				38	053				. 1	USA			
	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or items 23a or 28a-1 show that the Mudical Examiner must be notified at	Funeral	11. Maritai Status	12. Was Decedent E Armed Forces?	ver in U	.S. 13.	Vas Dece	dent of Hi	spanic Ori	igin? (Spe	ecify Yes or N Rican, etc.)	lo-		- America		
ဖွ	or ite	5	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 X N If Yes, Give	lo		i Tes, spe 1 □ Yes				rsican, etc.)			, White, e		
93	urai',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			1 1 1 63	2,541 140	Specify:				Specify:	White	e	
5	72 h	Completed	15. Decedent's Ed (Specify only highest gra			16a. Deced (Give	lent's Usua kind of wo	al Occupa	ation <i>furing m</i> os)	t of worki	ng	16b. K	ind of Bus	iness/Indi	ustry	
121	within lene. then	ם	Elementary/Secondary (0-12)	College (1-4 or 5	+)		emaker	se retired,)			0.4	n Home			
7	filed v Hygie other t		17. Father's Name (First, Middle, Last)			TIOTA	iiunci		10 Mothe	oda Nama	(First, Middl					
anc	be d ol	Be	Malcolm MacDonald Wil								Kelly Mo	•		,		
Ž	should be and Mental I is marked o	၉	19a. Informant's Name/Relationship (105 14-15-		/0								
Maryland 21215-0036	d 2 sho th and 7 is mu treum		Dr. Mark Reed/Son	ype, Filiti)							Route Num				Code)	
ď	ges 1 and 2 should be filed within 72 hours after death with the Marylan t of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28a-1 show if item 27 is marked other then "natural", or items 23a or 28a-1 show or other treumatic event, the Mudical Examinet must be notified at		20a. Method of Disposition			38 Winding Way Germantown Tenness sposition (Name of crematory or other place) Date						38139 ocation - C		m State		
Baltimore,	nt of nt of t: ff it		1 X Burial 2 ☐ Cremation 3 ☐		Non	thridge	ge Woodhaven Cem. 11/5/05									
ᆵ	rtme rtent njury		* 4 □Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer									141.1.1	ington	renne	52266	
Ва	permit. Pages Department of Inportent: If ite any injury or of		21. Signature of a direct Service Cool	Christina	na L. Hilton 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore 1							Mara Janet 01014				
			23a. Part1. Enter the disease, or com	plications that caused	the death	h Do not ente	305 Ha	artorc	I Road	Bali	timore M	arylaı	nd 21		Approximate	
	The law requires that the death certificate be executed XB XB XB XB XB XB XB XB XB XB XB XB XB	cal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a bue to (or a bue t	consequence of):									Onset and De	sath	
89	rtifical ng phy as th	Jedi	IF FEMALE:													
P.O. Box	it the death certific by the attending p tached for use as i	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live birth 12 4 Pregnant at 19 Unknown	2 ☐ Fetal	Ideath 3□	Ectopic pr Other (sp						23d. Date Monti		/ Day Ye	ar
٠, ٦	res that igned to be det	by P	Part II. Other significant conditions of	ontributing to death bu	t not resu	ulting in the un	derlying c	ause give	n in Part I.		23e. Did	tobacco u	se contrib	ute to the	cause of dea	ath?
Ë	w require been sig should b	edi									1 🗆	Yes 2	□No 3	☐ Probat	oly 4 (E)Uni	known
Vital Records,	aw re as be 2 sho	Completed									24a. Was		24b. We	ere autops	y findings av	allable
æ	The I	E				-					auto perf 1 ☐ Yes	ormed/	dea	ath?	oletion of cau □ No	se of
		0	25. Was case referred to medical						26. Place	of Death	(Check only			2103 2		
>	S S D	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatier	nt 2 🗆 1	ER/Outpatient	3 E DO	A Other	r: 4 🗆 Nui	rsing Hon	ne 5∐Res	idence (3 Other	(Specify)		
	ding Ph h. After th funeral	1 (27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year)	28b. Time of Injury	2	8c. Injury Work		_	8d. Describe					
<u>.</u>	E # : 0	atic	2 ☐ Accident investigation		,	,u.ry	М		es 2 🗆 N	No						
Division	of or Attend after death Director: d in by the t	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc.	ry - At ho	me, farm, stre	et, factory	, office		2	8f. Location (City or To	Street and	d Number	or Rural F	Route Numbe	ır,
	tefor rs afte ei Dire ed in t	Cer									.,,.,.	,,				
	Hospitef 14 hours Funerei tely filled	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	sician: To the best of iner: On the basis of	f my knov	wledge, death	occurred a	at the time	e, date and	d place, a	nd due to the	cause(s)	and mann	er as stat	ed.	
	the the	Medi	Uney .	and manner stat	ed.											
	5 tit		29b. Signature and title officertifier	dill				. License		,		29d. Date	e signed (Month, Da	ay, Year)	
•	***		1/100	rend of			1	120	138			111	01/0	5		
	10		30. Name and address of person who d	. \	_			Μ.	1	1	//	1		. 1 .		ME
			Trank Ji Cr		ND		100	1116	norio	21	HOZD!,	101	R	MILLY	nore,	עויו
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 4 2005	32. Registra	Sonat	A CONTRACTOR OF THE PARTY OF TH					1				,	

Registrar

State

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. MAMATHA PRABHAKAR, 3001, S. HANOVER STREET, BALTIMORE, DR. MARVI AND - 21325

MARYLAND - 21225

			1 - For State Registrar	State of M	aryland / (artment <i>tificate</i>			and M	-	gien Reg. M	2005	35726
	Physici		1. Decedent's Name (First, Middle, Las Nettie	")			Stewar	t			2. Date of De. Month October	Da		3. Time of Death 10:30 P ^M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, To		Location o				County of Death	10.30 1
			Mariner Nursing H	ome					ville			E	Baltimore	
	Funeral		5. Social Security Number 6. Se	x 7. Ag □ M 2⊠F	ge (In yrs. last bii	rthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da	y, Year		lace (State or Foreign try)
	Director		224-09-6683 Usual Residence of Decedent	- 1	91	113.					Sept. 4	+ , 1	914 Nort	h Carolina
	yland		10a. State 10b. County		10c. City, Tow	m or Lo	cation						11	0d. Inside City Limits
	a-fst	tor	Maryland		Balti	imor	e							1 XYes 2 No
	or 28	Director	10e. Street and Number				10f. Zip C	code				10g. C	itizen of What Coun	try?
	ath w		4728 Wakefield Ro				212						S.A.	
	items	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🕅	Ever in U.S.	13. \	Nas Decede f Yes, sp <i>ec</i> if	nt of His y Cubar	spanic Orig n, Mexican,	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)	.	14. Race - Americ Black, White,	
980	urs af	þ	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates:	140		I□Yes 2	X No	Specify:				Specify: Blac	k
Š	within 72 hours after death with the Maryland one. than "returel", or items 23e or 28e-1 show ite Madical Examilian mat be notified at	Completed	15. Decedent's Ed (Specify only highest grad		16a	. Deced	lent's Usual kind of work	Occupa	tion	of workin	ıa.	16b. l	Kind of Business/Inc	
2	ithin Per	nple	Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	OO NOT use	retired)	aning most	OI WOIKIII	9			
7	lled w tygier her th	S	8 17. Father's Name (First, Middle, Last)			Но	memak		19 Mothor	r's Namo	(First, Middle,		wn Home	
and	d be f	Be c	Percy Berry								Hinto		T Sumame)	
Maryland 21215-0036	should be filed vand Mental Hygies marked other tumatic event.	ဥ	19a. Informant's Name/Relationship (7	ype, Print)	195	o. Mailin	g Address (Street a					or Town, State, Zip	Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel; or items 23e or 28a-1 show any injury or other traumatic event, the Modical Examinator ast by notified at once.		Catherine Myrick	(Daughte	r) 4	4728	Wake:	fiel	d Rd	., Ba	altimor	e, :	MD 21216	Apt. 101
Baltimore,	of Hear litem		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆	Domoval from State	20b. Place o cemete	of Dispo	sition (Name	of er place)	Da	ate	20c. L	ocation - City or To	wn, State
Ĕ	Pages ment of I ent; If ite ury or o		`4 □Donation 5 □ Other (Specify)	Pleasa	ant	Hill (Ceme	tery	10/13	3/05	Su	ffolk, VA	
3alt	permit. Departr Importe any inje		21. Signature of Funeral Service Licent	and the second	000	22	Name and Crock	Address er l	of Facility	al Ho	ome			
	707 a 0		23a. Part1. Enter the disease, or comp	DOOL	d the death De	ant ant	900 E	Wa	shin	gton	St. S	uff	olk, VA 2	23434 Approximate
	Fnysician /Medical Examiner	(shock, of heart failure. List only of mediate dause (Final disease or sondition resulting in death)	aeach li	ne. C BU A a consequence	46	7,	7	-M)				Interval Between Onset and Death
8760,	death certificate be executed e attending physicien and ad for use as the burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence									
P.O. Box 68	that the death certific ed by the attending p detached for use as i	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death		Ectopic pred Other (spec						23d. Date of delive Month	ry Day Year
	sign sign d be	þ	Part II. Other significant conditions or	entributing to death b	out not resulting i	in the ur	nderlying cau	nse dine	n in Part I.			obacco /es 2	use contribute to the	e cause of death? ably : 4 Unknown
Vital Records,	The ate h page	Completed											prior to con death?	osy findings available apletion of cause of
Vita	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				-			(Check only o	/-		_
o	ding Phye	tlon: To	1 ☐ Yes 2 X No 27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	1 ☐ Inpati 28a. Date of Inju (Month, Da		utpatien Time of Injury		c. Injury Work	at	2	le 5 ☐ Resid 8d. Describe h		6 □Other (Specify rry occurred)
Division	tal or Attendi s after death, el Director: A ed in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	288. Flace of III	jury - At home, fa lc. <i>(Specify)</i>	arm, str	eet, factory,	office		2	8f. Location (S City or Tow		nd Number or Rural e)	Route Number,
	To the Hospital within 24 hours a To the Funerel Completely filled	edical	(Check only 2 Medical Exam	ysician: To the best iner: On the basis o and manner st	of examination ar	e, death nd/or inv	estigation, in	n my op	inion, deati	d place, a h occurre	nd due to the d d at the time, d	cause(s date an) and manner as sta d place, and due to	ated. the cause(s)
	Vith To T	Σ	29b. Signature and title of offitier	100K			9		number	7	4		te signed (Month, L	
,	^		· WINX	4/13		\	1/	5	10	×	2	cte	ber 11, 2	405
	17			ompleted cause of a	death (Item 23a)	(Type,	Print) 2E157	TER	+ARO	LD	BOB	MI	ber 11, 2 2 1136	
	Sta Registi		31. Date filed (Month, Day, Year) NOV 0 4 20	33 Registr	rar's Signature	God	de							

	1	For State Registrar	State of Mary		artmen ertificate				giene Reg. No.2	005	35727
Physician		1. Decedent's Name (First, Middle, Last) CYNTHIA	HOPE		SHA	ZKE	Y	2. Date of Dec Month NOVEN	Day	Year (1) Z005	3. Time of Death
/Medical Examiner		Ia. Fecility Name (If not institution, give s THE TOHNS HOPE)	treet and number)		4b. City,	Town, or L	ocation of Death	CITY		unty of Deeth	A
Funeral Director		5. Social Security Number 6. Sex 213-52-6177	7. Age (In	yrs. last birthday 59 Yrs.	y) If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da Sept. 20	h, Year)),1946	Cou	
d oth	10 be completed by runeral Director	10a. State Maryland Baltimore 10e. Street and Number 13221 Fork Road 11. Marital Status 1 Never Mamied 2 Married 3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) George Samos 19a. Informant's Name/Relationship (Ty Mr. Louis G. Sharke 20a. Method of Disposition 1 Bunal 2 Dremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	2. Was Decedent Eve Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Cation or completed) College (1-4or 5+) ()2 Dec. Print) Cy (Son)	19b. Ma 1020 20b. Place of Disconnetery, or Evans Fi	101. Zip 3. Was Decedif Yes, specifi Yes, specifi Yes 1 Yes 2 Seedent's Usus 2 Manag Manag Miling Address 6 Deer position (Nameral	210 lent of Hispan inty Cuban, 22No al Occupative dane du les retired) er (Street ar Cree ne of ther place, Chap	panic Origin? (Sp. Mexican, Puerto Specify: Ion 18. Mother's Nam 18. Mother's Nam 18. Mother or Run 18. Church 19. 19. 19. 19. 19. 19. 19. 19. 19. 19.	e (First, Middle), ne Stavn al Route Numbo n Road Date 02,2005	Unit 14. Sp. 16b. Kind Maiden Surides er, City or T. Fores 20c. Loca Fore	n of What Counted Sta Race - Ameri Black, White, Decity: Word Business/In Food S Immame)	tes can Indian, etc. hite idustry ervice p Code) ,MD.21050
ysicie	dicai Examiner	23a. Pari . Enter the disease, or completely key, or heart failure. Vist only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	onsequence of):		NG.					Inierval Between Onset and Death
the d	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown Part II, Other significant conditions co	23c. If yes, outcome of 1 Live birth 2 [4 Pregnant at tim 9 Unknown	Fetal death the of death	3 □Ectopic p 5 □ Other (s)	pecify)	n in Part I.	23e. Did		d. Date of delined Month	Day Year the cause of death?
igne gne bed	ò	Part II. Other significant conditions co	minouting to death but i	TOUR THE SURE REST OF THE	- underlying t	Auso give			Yes 2		obably 4 DUnknow
The law ate has b page 2 sl	Completed							24a. Was auto perfe 1 \(\text{Yes} \)		24b. Were aut prior to c death? 1 🗆 Yes	topsy findings available ompletion of cause of
ng Physic Iter this o	27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work?								Death (Check only one) g Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number,		
		29a, Certifier (Certifying Phy	sician: To the best of einer: On the basis of e	my knowledge, de	eath occurred	at the tim	e, date and place	, and due to the	wn, State) cause(s) as date and p	nd manner as lace, and due	stated. to the cause(s)
To the F within 24 To the F complete	Medical	29b. Signature and title of certifier	and manner state		29	c. License	number			signed (Month	
1		30. Name and address of person who	multiple cause of dea	th (Item 23a) (Tvi		ies ·	-000		NOVEN	IBER (1 2005
Stat Registra		CHRISTIAN MEYER, MD 31. Date filed (Month, Day, Year) 1005		topk Ins		rL, 600	NORTH WO	LFE STREE	T, BALTI	MORE, M	7 222 G

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25,27,28a-1 per ME 6349, 11/02/05dhb Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month tdene idenstricker /Medical Approximately Name (If not institution, give street and number)
Bel Air Houlthand 4b City, Town, or Location of Death 4c. County of Death **Examiner** If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Hours Year) 1 ☐ M 2 💆 F Director 212-05-1652 MARYL Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28e-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28e-f show idical Examiner must be notified at 1 ☐ Yes 2 No Director BALTIMORE BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21234 10115 USA NO rerguson Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White. 3 Widowed 4 □ Divorced th and Mental Hygiene.
7 is marked other than "natur traumetic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Clerk lephone 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stevens. trank ongte llow 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE, MD 2123 item 27 other tra Qrand daughter 10115 Ferguson Rd.

20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of I important: If its any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State BALTIMORE MD BALTIMORE National Com 9-29-05 * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility BACTIMORE, MD 21231. 21. Signature of Funeral Service any is EVANSFUNERALCHAPEL, 8800 HALFORDRD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician VVICA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transi Due to (or as a consequence of): Physician/Medical CAL EXAMINER 3 | Ectopic pregnancy CERTIFICATION APPROVED BY NEC IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregrant in the past 12 menths?
1 Yes 2 No 23d. Date of delivery ŏ Day Month Year 4 Pregnant at time of death 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 1€No 2 100 Division of Vital 25. Was case referred to medical Be 26. Place of Death Check on one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 😓 1 ☐ Inpatient 2 ☐ ER/Outpatrent 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner eath 28b. Time of 28d. Describe how injury occurred Certification: Unknown To the Hospital or Attending 5 Pending 1 ☐ Yes **X**☐ No within 24 hours after death. To the Funeral Director: A 2X Accident 3 Suicide 09/06/2005 Subject fell investigation filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Assisted Living facility 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 8100 Rossville Blvd., White 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 2000

Registrar

30. Name and address of person who com-

NOV 0 4 2005

31. Date filed (Month, Day, Year)

se of death (Item 23a) (Type, Print)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) November 3, 2005 2005 10:30 P™ **Physician** Elmer Robert Sturgeon /Medical 4c. County of Death 4b City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Baltimore Dundalk 7014 Belclare Road If Under 24 Hrs. 9. Birthplace (State or Foreign If Under 1 Year 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Min. 10/23/1951 Days Hours Maryland 1 M 2 □ F 54 216-58-4858 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic svent, it s Maxical Examiner must be notified at 1 Yes 2 No Dundalk Director Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 7014 Belclare Road 21222 Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 2 should be filed within 72 hours after in and Mental Hygiene.

Is marked other than "natural", or Iter 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify. Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Property Management 2 Maintenance Years 18 Mother's Name (First Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Barbara Clark Elmer L. Sturgeon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7014 Belclare Road Dundalk, Maryland 21222 Theresa A. Sturgeon / Wife item 27 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State ₹ <u></u> Sacred Heart of Jesus 11/07/2005 Baltimore, Maryland ō Department of Important: If any injury or once. 22. Name and Address of Facility David J. Weber Funeral Homes PA Funeral Service dicens 401 S. Chester Street Baltimore, Maryland 21231 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 3 months Pnysician Metestatic Lung /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth Dav Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Acth ma Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 00 Hospital or Attending Physician: 26. Place of Death (Check on one Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ₹ No Certification: To his 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of 27. Manner of Death After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 2005 we MD D0052928 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BLVD STE 200 BAUTIMORE MD 21236 CAMPBELL ANNE NADIRY MO 4924 31. Date filed (Month, Day, Year) . Registrar's Signature State NOV 0 4 2005 Registrar

NOVEMBER 1, 2005 11:55 a.m.	Baltimore, Maryland 21215-0036	permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland
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ALAN STREB

		_	For State Registrar		State of Ma	iryland /			t of H				Reg. No	11115	3	5730
	Physicia	an	1. Decedent's Name (First, M								-	2. Date of De Month	Da			Time of Death
	/Medic	al	ALAN J. S. 4a. Facility Name (If not instit		reet and number)			4b. City	Town, or	Location of		IOVEMBE		, 2005 c. County of De		11:55 A,
	Examin	er	STELLA MARIS						MONIU					BALTIM		
***	Funeral Director		5. Social Security Number 219-28-7395	6. Sex		(In yrs. last	birthday) Yrs.	If Unde Months	r 1 Year Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Bir (Month, Da 3/12/	th ay, Year 1932	9. B MA	irthplace Country) RYL	(State or Foreign
	and	1	Usual Residence of Decedent 10a. State 10b. Co.			10c. City, To	own or Lo	cation							10d.	fnside City Limits
	the Marylar 28a-f show	ğ	MD BAI	TIMOR	E	GLE	N ARM	1								1 ☐ Yes 2 🛣 No
	ith the	Director	10e. Street and Number					10f. Zi	o Code				10g. C	itizen of What (Country?	
	th with	aiD	26 GUNPOWDER	ROAD				2	1057					USA		
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7	il Hygiene. Other then vent, the M	Соп		4	+ YEARS	, Di	EPUII	ASS	TOTAL				OF		NMEN	VT
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Ž	should be nd Mental marked o	ဥ	19a. Informant's Name/Relat			1	19b. Mailin	a Addres	s (Street a					or Town, State,	Zip Cod	de)
2	nd 2 salth ar 27 is		DOROTHY STREE				26 GL	-				J ARM,		21057	,	,
בי מ	permit. Pages 1 and 2 Department of Health 8 Important: if item 27 ti eny injury or other tra 2008.		20a. Method of Disposition 1 Burial 2	ion 3 🗆 Re			of Disposition of OHN T	HE E		LIST	102000	ate /2005		ocation - City o		State
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00			IF FEMALE:													
0.00	To the Mospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnan in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	t 23	3c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal de	ath 3	Ectopic p Other (s	regnancy pecify)					23d. Date of d Month	elivery Day	y Year
ָר על, ה	quires that in signed b	by	Part ff. Other significant cor	iditions con	tributing to death bu	ut not resultin	ng in the ur	nderlying	cause give	in in Part I.			tobacco Yes 2	use contribute 2 □ No 3 □ F		ause of death?
חמפר	The law re ete has be page 2 sho	Completed										24a. Was auto perf 1 Yes	psy ormed?	prior to death?	o comple	findings available ation of cause of
2	ician: sertific ector,	Be	25. Was case referred to me examiner?		ospital:				Otho			(Check only				
5	Physic rthis ral dir	: To	1 ☐ Yes 2 🙀 No 27. Manner of Death		1 ☐ Inpatie 28a. Date of fnjur		Outpatien b. Time of			4 🗀 [40]		ne 5 ☐ Res		6 NOther (Sp	ecify)	HOSPICE
5	th. : Afte	tion	1 XNaturaf 5 ☐ Pe	ending restigation	(Month, Day	i Year)	Injury	м	28c. Injury Work 1 ☐ \	? /es 2 ☐ N	10			,		
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 ☐ Suicide 6 ☐ C	ould not be termined	28e. Place of Injubulg	ury - At home c. (Specify)	, farm, str	eet, facto	y, office		2	8f. Location City or To		ind Number or I te)	Rural Ro	ute Number,
	he Hospit n 24 hour se Funera	edical			ician: To the best of er: On the basis of and manner sta	examination										
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State of Maryland / Department of Health and Mental Hygiether 15 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** P^{M} 3, 2005 1:40 November Smith Mae /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 3112 Whiteway ROad Edgemere Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year March 5, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🕱 F วี930 Director 75 Maryland 212-32-1178 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State item 27 is marked other than "natural", or items 23s or 28e-f show other treumatic event. The Medical Examinar must be notified at 1 ☐ Yes 2 No Director Baltimore Edgemere 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21219 USA 3112 Whiteway Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene. Is marked other than "natural", or Iter ☐Yes 2 No Yes, Give 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: White Specify: If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) Teachers Aid 12 years Public Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Catherine Reese Robert F. Altvater 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ent: If item 27 is ury or other treu 3112 Whiteway Road, Edgemere, Md. 21219 Robert Smith 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition November 1 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. '4 Donation 5 Other (Specify) 2005 Parkville, MD. Moreland Memorial 7, 21. Simulative of Funeral Service License 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 Approximate Interval Between Onset and Death 23a. Part1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final diseas condition resulting in death) 3 months Physician LUNG CANCER /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease of Figure that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown RIGHT LEG DVT 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an CVA WIT RIGHT HEMIPARESIS certificate has autopsy performed 2 No 1 Yes Division of Vital ours after death.

Nerel Director: After this certifical filled in by the funeral director, To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 ☐ Yes 2 No ٢ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number HEMATOLOGIST 2005 D-51555 MD ONCOLOGIST 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SQUARE DRIVE, SUITE #2200 , BALTIMORE MD 21237 FRANKLIN AUNG SEIN 2. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 4 2005 Registrar

DHMH 17 Rev 1/2001

Amend Item 23a per Dr. Geografia and Mental Hygiene 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** SHAFFER 1224 PM BARBARA J. 31 OLTUBEL 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** RANDALLSTONN BALTIMORE NURTHWEST ITOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 □ F Yrs 55 **Director** 219-70-5840 MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 23a 3306 HILLSMERE ROAD 21207 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "netural', or items 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or iter any injury or other traumatic event, the Medical Examinat 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 200 No WHITE þ Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NONE NONE 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) DAVID SHAFFER SHEMER LILLIAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3306 HILLSMERE ROAD - BALTIMORE, MD 21207 LILLIAN SHAFFER / MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) BETH EL MEMORIAL PARK 11/02/2005 RANDALLSTOWN, MD 21. Signature of Fyheral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** days Cardia arrest /Medical Due to (or as a consequence of): Examiner rend facture chronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed burial-transit Myocardial Infarction days Due to (or as a consequence of): ed by the attending physician detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient Certification: To 3∏ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral to
completely filled o the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Distyon October 31 20059736 mo 2005 To Matte and society of pattern who indmpleted tracks of death (flat) \$250 (Type Print) WATS DA mo NORTHWEST HOUP, TAL 5401 000 COURT ROAD DEBURAH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 4 2005 Registrar

		1	1 - State of Maryland / Department of Health and Mer Certificate of Death	ntal Hygie, _{Reg} .	2005 600
	Physicia			Date of Death	3. Time of Death 12:05 PM _M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4515 Old Licksville Road 4b. City, Town, or Location of Death Point of Rocks		4c_County of Death Frederick
	Funeral Director		5. Social Security Number 1 A 6. Sex 1 Months Days Hours Min. 1 M X F 80 Yrs. 1 Days Hours Min. De	Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Mary Land
	D		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	the Mary 28e-f sh	rector	Maryland Frederick Point of Rocks 10e. Street and Number 10f. Zip Code	10g.	1 ☐ Yes 2 No Citizen of What Country?
	s 23a or	Funeral Director	4515 Old Licksville Road 21777 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify		U.S.A.
36	be filed within 72 hours after death with the Maryland Hygiene. di Hygiene. di other than "natural", or items 23a or 28e-f show do other than "natural", or items 23a or 28e-f show event, the Medical Exertirer: and be notified at			an, etc.)	Black, White, etc. Specify: White
21215-0036	in 72 hou "natura edical E	Completed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b	b. Kind of Business/Industry
1212	filed withi Hygiene. other than	Comp	Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (Fi		wn Home
Maryland	ed is b	To Be	Alvie Edward Toms Mollie	Leona H	arne
	s 1 and 2 should of Health and Mer Item 27 Is marke other treumatic		19a. Informant's Name/Relationship (Type, Print) Mrs. Joan L. Babb, daughter 19b. Mailing Address (Street and Number or Rural Ru 4515 Old Licksville Rd.	, Point	of Rocks, MD 21777
altimore,	Pages 1 and the nent of He nut: If Item		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Method of Disposition (Name of cemetery, crematory or other place) 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		Wolfsville, MD
Balti	permit. Pages Department of Important: If It any injury or once.		21. Six subre of Funeral Service Licensee MOO255 22. Name and Address of Facility Keeney and Basford I 106 East Church St.	PA Funer Freder	al Home ick, MD 21701
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reshock, or heart failure. List only one cause on each line.	2.	Onset and Death
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	lsit ex	niner	Sequentially list conditions, if any leading to innectate cause. Enter Underlying Cause (Disease or injury		
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68769	# Dog	Medicai			
.O. Box	es that the death certific igned by the attending f be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delivery Month Day Year
<u> </u>	The law requires that the site has been signed by the bage 2 should be detache	b	Tark in order organization consistency of contract of the cont	23e. Did tobac	co use contribute to the cause of death? 2 □ No 3 □ Probably 4 □Unknown
Vital Records,	ne law require s has been si, ge 2 should b	Completed		24a. Was an autopsy performed	
Vital	ician: Ti sertificate ector, pa	Be	25. Was case referred to medical examiner? 4. Cyber Corporate Cor	201	
on of	ling Phys. After this (tuneral dir	ion; To	T Tes Zano T Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Home	5 Residence d. Describe how	e 6 □Other (Specify) injury occurred
Division of	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Location (Stree City or Town, S	et and Number or Rural Route Number, State)
_	Hospitel 24 hours Funeral tely filled	Medical Co			
	To the within 2 To the comple	Med	29b. Signature and title of certifier 29c. License number		Date signed (Month, Day, Year)
•	12		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		October 31, 2005
	St	ate	Elliamy Eskander MD 501 W 7th street + 31. Date filed (Month, Day, Year) NOV 0 4 2005	reden(1/1/D 21/01
	Regist		NOV 0 4 2005 Back 10 19		

			for State Registrar	State of Maryland		rtment of F		Mental Hy	giene	005	35731.
2			Decedent's Name (First, Middle, La	st)				2. Date of D	eath	500	3. Time of Death
	Physic /Medi		Milford R. Si	mmons				Month Oct.	Day 31. 20	Year 105	1:15 n M
	Examir		4a. Facility Name (If not institution, giv			4b. City, Town, o	r Location of Death			ounty of Death	
			Gilchrist Hospi			Towson			Ba1	timore	
	Funeral Director		5. Social Security Number 6. S	I₩ 2□F	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	ay, Year)	Cou	place (State or Foreign intry)
	- 5-2		234-10-3268 Usual Residence of Decedent	89	110.			Feb. 25	, 191	6 West	t_VA
	ehow		10a. State 10b. County	10c. City,	Town or Loc	ation					10d. Inside City Limits
	e Ma	Director	MD Baltimo	re Midd	lle Ri	ver.					1 ☐ Yes 2☐ No
	or 28	Jire	10e. Street and Number			10f. Zip Code			10g. Citize	n of What Cou	intry?
	ath w		123 Coverwagon	Y		21220				USA	
	er de	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?		las Decedent of H Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	0- 14	. Race - Amen Black, White,	
215-0036	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. In marked other than "natural", or items 23e or 28e-1 show maric event, it a Madical Exaction matter indified at	by	1 ☐ Never Married 2 ☐ Married 3 🍎 Widowed 4 ☐ Divorced	1 Tes 2 No If Yes, Give The Year or Dates:	1	☐ Yes 2☐ No	Specify: whi	te	S	pecify: wh	nite
- 0-	72 hours 'natural', olcel Exe	ted	15. Decedent's E	ducation	16a. Decede	ent's Usual Occup	ation		16b. Kind	of Business/In	
215	d within 72 ho piene. Ir than "natur Ir e Medicel	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	(Give k life. D	ind of work done of O NOT use retired	during most of work 1)	ing			,
77	ed wi	Con	4th		Factor	y Worker			Go	od Year	^
nd	be filed Ital Hyg od othe event,	Be	17. Father's Name (First, Middle, Last,				18. Mother's Nam		,	imame)	
<u>\$</u>	d 2 should be filed with th and Mental Hygiene. 7 ie marked other thar traumatic event, tra M	은	Floyd C. Simmons				Celia L.				
Maryland	7 is	1	19a. Informant's Name/Relationship (Kayrl Painter –				and Number or Run				
	s 1 and 2 of Health item 27 i		20a. Method of Disposition	20b. Pla	ce of Dispos	ition (Name of	Rd. Mid	are Kiv		tion - City or To	
Baltimore,	9 4 -		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	netery, crem	atory or other plac	e)				
, ‡	그 된 원 등 .	1	21. Signature of Funeral Service Lifer	TIOTI	.y H111	Mem. Ga	arden Nov	.3, 05	Midd	le Rive	er
ñ	Depa Impo any ir	1, 1/2	+ KIM A	Wlange.			ens Ave.				
V To			23a. Part . Enter the disease, or com shock, or heart failure. List only	plications that caused the death.						ary rand	Approximate
	Physician		Immediate Cause (Final disease or condition	m. (t	- 1	muel	UMA				Interval Between Onset and Death
7	/Medical		resulting in death)	a. Due to (or as a conseque	1000	000700	CY VIA				Jean
	Examiner		Sequentially list conditions,	b							
	sit sit	iner	if any, feading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	nce of).						
2/0	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conseque	man of):						
8760,	be ey			Dua to (or as a conseque	nce or).						
		dicai		d							
×	death certific e attending p id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnand					234	l. Date of delive	200
ă.	death d for	iciai	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea		ctopic pregnancy Other (specify)			230	Month	Day Y <i>e</i> ar
		hys	9 Unknown	9 Unknown							
S, F	The law requires that the de ate has been signed by the page 2 should be detached	by P	Part II. Other significant conditions of	ontributing to death but not result	ing in the und	lerlying cause give	in in Part I.	23e. Did t	obacco use	contribute to th	ne cause of death?
ğ	w require been si should b					_		1 🗆 🕆	Yes 201	lo 3 ☐ Prob	pably 4 DUnknown
Records,	elawr hasbe je 2sh	Completed						24a. Was	an 2	4b. Were auto	psy findings available mpletion of cause of
		Con						autor perfo	rmed?	death?	
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?				26. Place of Death		пе)		
of	d S	2	1 ☐ Yes 2 ☑ No 27. Manner of Death		VOutpatient	3□ DOA Othe	4 Nursing Ho			Other (Specify	nto spice
	fler fler	tion	1 Matural 5 Pending	(Month, Day Year)	8b. Time of Injury	28c. Injury Work		28d. Describe l	now injury oc	curred	,
Division	Attending r death. sctor: After by the fune	fica	3 Suicide 6 ☐ Could not be		e farm stree		′es 2 □No	28f Location (Stroot and N	lumbas as Our	l Route Number,
Ö	al or after after Dire	Certification:	4 Homicide determined	building, etc. (Specify)	0, 141111, 51100	n, lactory, office		City or Tov	vn, State)	UNDER OF MUTA	r Hobie Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to		29a. Certifier 1 Certifying Ph	ysician: To the best of my knowl	edge, death o	occurred at the time	e, date and place, a	and due to the	cause(s) and	d manner as st	ated.
	he Hin 24 he Fu	edical	(Check only 2 Medical Examone)	niner: On the basis of examination and manner stated.	n and/or inve	stigation, in my op	inion, death occurre	ed at the time,	date and pla	ce, and due to	the cause(s)
	To T	Σ	29b. Signature and title of certifier	10	-0	29c. License				gned (Month, I	
	7		1/ Halh	y May 1	(2)	102	2907	(ctol	ie 31,	2005
	10		30. Name and address of person who	completed cause 1 sath (Item 2	3a) (Type, Pr	int) _ lo	St. B	alts 1	u1 >	2/206	
	Total Co.		31. Date filed (Month Day, Year)	32 Denietrada Sina st	11.	101	-11 12	-700	ς.		
	Sta Registr	100	eras a s	32 egistrar's Signatur	Los	AU.					
DHM	IH 17 Rev 1/20		NUV U 4 ZU	ous present to							

ORIGINAL

			1 - For State	State	of Man	yland / De	partmen e <i>rtificat</i>					. 0	nns	2570) C
			Registrar 1. Decedent's Name (First, Middle,	Last)			Chinoat	01 2	- Catri		2. Date of De	Reg. Nó. ath	000	3. Time of D) oeath
	Physici		Virginia Le		Horn						Month Novemb	Day	Year 2005	7:00A	М
	/Medic Examir		4a. Facility Name (If not institution,				4b. City,	Town, or I	Location of		NOVEIR		County of Death	7 . OOA	
	LXAIIII	iei	Chesapeake Nursi	ing & Re	hab.	Center	Arno	old.				An	ne Arun	de1	
	Funeral			S. Sex		n yrs. last birthda	y) If Under	1 Year	If Under		8. Date of Bir	th		place (State or a	Foreign
	Director		234-01-6064	1 ☐ M 2 🖾 F		89 Yrs	Months	Days	Hours	Min.	(Month, Da	19,1	916 West	"Virgin	ia
	D >		Usual Residence of Decedent 10a. State 10b. County		10	Dc. City, Town or	1						T T	404 1-14-07	41
	ehor	5			10	•								10d. Inside City	
	28a-f	Director	Maryland n/a			Balt	imore	0-4		· · · · · · · · · · · · · · · · · · ·		10- Chi	izen of What Cou		
	a or	ā					10f. Zip		20			•		intry t	
	eath	era	1926 Letitia A	12. Was Dec	edent Eve	rin II.S. 1	3 Was Dece	212		inin? (Spec	cify Yes or No		S.A.	ican Indian	
(0	r Iten	Funerai	1 Never Married 2 Marrie	Armed F	orces? 2X No				, Mexicar	n, Puerto F	city Yes or No Rican, etc.)		Black, White		
93	al', o	by	3 ☑ Widowed 4 □ Divorced	If Yes, G Year or I			1 🗆 Yes	2█ No	Specify:	:			Specify: Wh:	ite	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itema 23a or 28a-f ehow fite Medical Exempler mast be notified at	Completed by	15. Decedent's (Specify only highest)	16a. De	cedent's Usua ve kind of wo	al Occupat	tion	st of workin	ıa	16b. Kii	nd of Business/Ir	ndustry	
7	ithin Ber	npjdu	Elementary/Secondary (0-12)		(1-4or 5+)	life	. DO NOT us	se retired)	oring mod		3				
2	led w tygier her ti		12			Ho	usewii		10 11-11-		(F) . 147.44		wn Home		
and	ntal F	Be	17. Father's Name (First, Middle, La								(First, Middle				
Ž	d Mel d Mel mark matic	ပ	Franklin A. (10h M	ulina Addrona	(Stroot o		telia			r Town, State, Zi	n Codo)	
Maryland	d 2 s th an trau		Gwenolyn Fabula	(Daugh:	ter)		•						ark, Md	,	
ē,	Hee Hee tem		20a. Method of Disposition	(Daugh		20b. Place of Dis	position (Nar	ne of	1		ate		cation - City or T		
E O	Pages ent of nt: If I		1 XBurial 2 ☐ Cremation 3 '4 ☐ Donation 5 ☐ Other (Spe			Glen Hav	rematory or o			11-7-	05	Glan	Burnie	Marula	and
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene. Department of Heelih and Mental Hygiene. In proportent: If Item 27 is marked other than "natural; or Itema 23s or 28s-f show any injury or other traumatic event, the Madical Examinat must be notified at once.		21. Signature of Fineral Service Li	1	1	1	22. Name an	d Address	s of Facili	itv					ina
m	Depa impo any is		Kennen	1la	100	(ii)	litzke 630 Ed	Fune Imond	ral	Home Ave	of Cat	onsv	ille, In	nc. land 21:	228
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Beh												Approximate Interval Betwe	
E	Physician		Immediate Cause (Final disease or condition Chronic Chetruct ise Pulmonar, disease or condition										Onset and De		
	/Medical		resulting in death) Due to (or as a consequence of):												
	Examiner	_	Sequentially list conditions,	b	4.										
10	sit sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a co	onsequence of):									
4	and and Il-tran	хап	that initiated events resulting in death) Last	c	(or as a co	onsequence of);									
8760,	ate be executèd hysician and the burial-transit	aiE		W.	,										
687		edicai		d											
Вох	death certifica e attending pl ed for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or								1	23d. Date of deliv	/ery	
Ď	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐Preg	nant at tim		3 □Ectopic pr 5 □ Other (sp						Month	Day Ye	ear .
<u>о</u> .	res that the de igned by the a be detached f	hys	9 ☐ Unknown	9□ Unkr	nown										
S,	The law requires that the site has been signed by the bage 2 should be detached.	ру Р	Part II. Other significant condition	s contributing to	death but n	ot resulting in the	underlying c	ause give	n in Part I	l.	23e. Did 1	obacco u	use contribute to	the cause of dea	ath?
ğ	w require been si should b	ted									1 🗆	Yes 2	□No 3 Pro	bably 4 🗇 Un	known
Record	law ras be	pie									24a. Was		24b. Were aut	opsy findings av	vailable
		Completed									perfo 1 ☐ Yes	2 No	death?	2 No	
Vital	Physician: The lav this certificete has al director, page 2	Be	25. Was case referred to medical examiner?					T .		e of Death	(Check only	one)	-		
of O	Physic this c	2	1 Yes 2 To			2 ER/Outpa			4 IL TVI				6 □Other (Spec	ify)	
Division of	ding F h. After funera	ertification;	27. Manner of Death 1 □ Matural 5 □ Pending		of Injury oth, Day Ye	28b. Time Injur		8c. Injury Work	at ? ′es 2 □		8d. Describe	now injur	y occurred		
2	death death ctor: / the	ical	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	be as Dies	e of Injuny	- At home, farm,			65 2 🗆		8f Location (Street an	d Number or Rui	al Boute Numbe	97
<u>></u>	spital or At ours after eral Direc filled in by	ertii	4 Homicide determine	build	ling, etc. (S	Specity)	street, ractory	, onice		-	City or To	wn, State)	u. 1 10010 1101110	J.,
	spita nours neral / fillex	ai C	29a. Certifier 1 Dertifying	Physicien: To th	e best of m	ny knowledge, de	ath occurred	at the time	e, date ar	nd place, a	nd due to the	cause(s)	and manner as	stated.	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director;	edicai	(Check only 2 Medicel Ex	aminer: On the I	nasis of exa ner stated	amination and/or l.	investigation	, in my opi	inion, dea	ath occurre	d at the time,	date and	place, and due	to the cause(s)	
	To t	Σ	29b. Signature and title of certifier		1	_ \	290	License	number	7~		29d. Dat	te signed (Month	Day, Year)	1
					/ _		'IU	DO	0/6	25		1/	-/-	du C	7
	3		30 Name and address of person wh	completed cau	se of death	h (Item 23a) (Typ	e, Print)	1.	11	11	11	n	11	2110	<u></u>
			31. Date filed (Month, Day, Year)	10981	2001	VOTER	apsil	44	101	ices	Vill	<u> </u>	1010	0110	5
	Sta Registra				logistiat S	Signature	(dept)	0				-			
		-	NOV 0 4 2	UUJ		N									

			For State Registrar	State of Mar	•	epartmer Certifica:			-	giene Reg. No.C	2005	35736
***	Physicia /Medic		1. Decedent's Name (First, Middle, La	MAY	WH	ITNE	Y		2. Date of De Month	Day	Year 2005	3. Time of Death
	Examin		4a. Facility Name (If not institution, give			1		Location of Death	1	4c. (County of Death	
	Formati		Howard County Ge 5. Social Security Number 6.5		tal (In yrs. last birth		Colum	bia If Under 24 Hrs.	8. Date of Bir	th	Howard	place (State or Foreign
	Funeral Director			□M 2 X F		Months	Days	Hours Min.	OCT 25	192	5 Mar	place (State or Foreign intry) Cyland
	p .		Usual Residence of Decedent		10a City Taylo							
	death with the Maryland ms 23a or 28e-f ehow craust be notified at	2	10a. State 10b. County	_	10c. City, Town		0.1	1 .				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the N	Director	Maryland Howai	rd			Colum	nb1a		10g Citiz	en of What Cou	
	3a or		5493 Woodenhawk	Circle		101. 21	210	44	5	rog. Oitiz	USA	
	death	Funerai	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S.	13. Was Dece		spanic Origin? (S n, Mexican, Puert	pecify Yes or No)- 1	4. Race - Ameri	
0030	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. Item 27 is marked other then "naturel", or items 23s or 28s-f show other traumatic event, the Mudical Exercities must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Novorced	1 Yes 2 No If Yes, Give Year or Dates:		1 Tes, spe		Specify:	o rican, etc.)		Black, White, Specify: W	hite
ה ה	72 hc	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. C	ecedent's Usu Give kind of w	ial Occupat	tion uring most of wor	rking	16b. Kin	d of Business/Ir	ndustry
Z	hen.	mpi	Elementary/Secondary (0-12)	College (1-4or 5+))			3	3		TT	
N	Hygie Hygie other t		17. Father's Name (First, Middle, Last)	1	Iomemak		18. Mother's Nan	ne (First, Middle		1 Home	
au	ld be ental ked o	To Be	William Butler						1 Celes			1
ary	and M le mar	-	19a, Informant's Name/Relationship		19b. I	Mailing Addres	s (Street ar	nd Number or Ru				
Ž,	and 2 lealth a m 27 is		William A. Whitn	ey, III/Son	54	93 Wood	denha	wk Circl	e Colu	mbia,	MD 210)44
ore	of He fiterr		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐	Removal from State	20b. Place of Cometery	Disposition (Na , crematory or	me of other place)	Date	20c. Loc	ation - City or T	own, State
aitimo	Pag ment ant: I		4 Donation 5 Other (Speci		Metro (2/05		imore,	
gail	permit. Pages Depertment of Important: If I eny injury or pnce.		21. Signature of Funeral Service Lice	5 gonn		22. Name a	nd Address	s of Facility Cr	emation	Soci	ety of	MD, Inc.
ĥ	45204		Edward A Greg 23a. Part1. Enter the disease, or com	orchik	he death Do no			ick Road			MD 212.	28 Approximate
	Di di di		shock, or heart failure. List only Immediate Cause (Final	one cause on each line	A 6	10						Interval Between Onset and Death
je.	Physician /Medical		disease or condition resulting in death)	a. (DION OV o	consequence of	1 dise	ge ,	POST by	pay graf	1 Sugar	4.	
	Examiner			Sepcis	-						a	
ř	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):						
	ecute and trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c								
δ,	cate be executed physician and the burial-transi		resulting in death) Last	Due to (or as a	consequence of):						
28/60	certificate be executed nding physician and use as the burial-transii	dica	•	d								
XOX ROX	n requires that the death certific been signed by the ettending f should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of						2:	3d. Date of deliv	rerv
-	death e ette	iciai	in the past 12 months? 1 ☐ Yes 2 ☑ No	1□Live birth 2 4□Pregnant at ti		3 □Ectopic p 5 □ Other (s					Month	Day Year
5	requires that the death een signed by the etter hould be detached for u	hys	9 Unknown	9 Unknown								
	es the	ρ	Part II. Other significant conditions		not resulting in	the underlying	cause givei	n in Part I.				the cause of death?
ord	seen s bould	ted	Dan entia	droycod S	tage				10	Yes 2	No 3 Pro	bably 4 Unknown
Hecords	as s	Completed							24a. Was	psy	24b. Were auto prior to co	opsy findings available impletion of cause of
	ician: The certificete h rector, page								1 Tes	2 No	death?	2□ No
VItal		Ве	25. Was case referred to medical examiner?	Hospital:	-5550	1000	Othe	26. Place of Dea				
ō	Phys or this aral di	ı: Το	1 Yes 2 No 27. Manner of Death	1 Impatient	28b. Ti		28c. Injury Work	4 🗆 14013111g 1	lome 5 Resi			<i>h</i> y)
0	Attending ir death. ector: After by the fune	ation	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Inj	ury M		? ′es 2 □ No				
DIVISION	or Attendi after death. Director: A	Certification:	3 Suicide 6 Could not to determined		y - At home, fam (Specify)	m, street, facto	ry, office		28f. Location (City or To	Street and wn, State)	Number or Run	al Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier 1 Certifying P (Check only one)	hysician: To the best of miner: On the basis of e and manner state	examination and	death occurred for investigation	at the time	e, date and place inion, death occu	a, and due to the urred at the time,	cause(s) a	and manner as s place, and due t	stated, to the cause(s)
	ro the vithin roughly completed	₩ We	29b. Signature and title of certifier			29	c. License			29d. Date	signed (Month,	Day, Year)
			Dudak 8	erzingi	MO		000	56986		10-	30-200	05
	1.		30. Name and address of person who	completed cause of dea	ath (Item 23a) (T	ype, Print)						05 If MD 2077
	7			Berzingi	750	o lto	harer ,	pr-kway	Suit 10	15	Greenbel	+ MD 2077
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	-	,	U				
DH	MH 17 Rev 1/2		NOV 0 4 2	105 Stephen	· H	marke)						
υn	17 Dev 1/2	001			6							

NOVEMBER

DOROTHY

			1 - For State Registrar	State of Maryl		epartment of Certificate of			giene 005	35738
	Physicia /Medic		1. Decedent's Name (First, Middle, La	y. Wo	N			2. Date of De.	Day 3 / 20	3. Time of Death
	Examin		4a. Facility Name (If not institution, give Howard County Gen	eral Hospita		Co1	or Location of De Lumbia			County
	Funeral Director		5. Social Security Number 213-29-7009 Usual Residence of Decedent	7. Age (in)	yrs. last birti	Months Day		lin. (Month, Da	y, Year) er 22,75 S	Birthplace (State or Foreign Country) eoul, Korea
	Maryland	tor	10a. State 10b. County Maryland Howard			or Location			-	10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	h with the 23a or 28 st be not	Funeral Director	10e. Street and Number 4972 Ellis Lane			10f. Zip Code	21043		10g. Citizen of What United St	
036	within 72 hours after death with the Maryland iene. r then "natural", or flams 23a or 28a-f show the Medical Evamiliat must be modified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever of Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	n U.S.	13. Was Decedent or If Yes, specify Cu	f Hispanic Origin? ıban, Mexican, Pu	(Specify Yes or No Jerto Rican, etc.)	- 14. Race - A Black, W	merican Indian,
9500-6121	within ene. than "	Completed	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12)		16a.	Decedent's Usual Occ (Give kind of work don life. DO NOT use reti HOME Mak	e during most of (red)	working	16b. Kind of Busine	ss/Industry
and 2	be filed Ital Hyg Ital otha evant,	Be	17. Father's Name (First, Middle, Last Jong Ku Won			HOME Har	18. Mother's N	Name <i>(First, Middle,</i> Sin Kim	Own Maiden Sumame)	nome
Mary	nd 2 should alth and Men 27 Is marks ir traumatic	υ	19a. Informant's Name/Relationship (Mailing Address (Stree	et and Number or	Rural Route Numbe		
Baitimore,	of He		20a. Method of Disposition 1 登Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Special	Removal from State	b. Place of cemetery	Disposition (Name of y, crematory or other p V Valley Me	lace)	Nov.02, 2005	y, Maryla 20c. Location - City Timonium,	or Town, State
Bail	permit. Page Department Important: If any njury o		21. Signature of Funeral Service Lice	L. gair,	lz.	Peacoful 2325 York	ress of Facility Iternati Road	ives Funei		ation Ctr.P.A 21093
	Physician		23a. P. 1. Enter the dise is or come shock, or heart failutist only ist only immediate Cause (Final disease or condition	plication that caused the cone cause on each line.	1 -	ot enter the mode of t	ying, such as card	diac or respiratory ar	rest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Sequentially list conditions.	Due to (or as a con	heo.	monia				days
	cate be executed ohysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a con						
09/89	ficate be e physician is the buria	dlcal	(d						-
O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burral-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☑ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ I 4 ☐ Pregnant at time 9 ☐ Unknown	etal death	3 □Ectopic pregnar 5 □ Other (specify)	су		23d. Date of Month	delivery Day Year
ecords, P.	n requires that the de been signed by the should be detached		Part II. Other significant conditions of Acult Respire	contributing to death but not	resulting in	the underlying cause of	given in Part I.			to the cause of death? Probably 4 Whiknown
I		Completed by	Bronchogenic	- Carci	neme	i				
or vital	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No		2 ER/Out	patient SI DOA	ther: 4 Nursing	_	dence 6 Other (S	pecify)
Division	Attending death. ictor: After y the funer	Certification;	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be determined	e co- Diagon of Injury	At home, far	ijury W M 1	□Yes 2□No	28f. Location (S	Street and Number or	Rural Route Number,
2	To the Hospital or within 24 hours after within 24 hours after To the Funeral Direct completely filled in b		29a. Certifier Certifying Pl	nysician: To the best of my	knowledge	death occurred at the	time, date and pla	City or Tox	railse(s) and manner	as stated.
	To the Hos within 24 ha To the Fun completely	Medical	29b. Signature and tiple of certifier	and manner stated.			nse number		29d. Date signed (Mo	
	h		30 Name and address of person who	completed cause of death	(Item 23a) (33621	1 01	Oct 31	2005
	Sta		31. Date filed (Month, Day, Year) NOV 0 4 200	ATEMA M. Registrar's S Machine Machi) /0 ignature	124 Little	e papye	ent PKW	y Colum	bia MD
	Registr	aı	14() 0 7 200	J KARTHEN)	The first	MARI				

			1- For Amend Items 25, 280 per ME, C8	•	Hygien 2005 35740
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) WILLIE PRESTON WOODWARD, SR.	2. Date Month Octob	of Death h Day Year 6 2045 0015 PM
	Examin	er	4a. Facility Name (If not institution, give street and number) WION MEMORIAL HOSPITAL	4b. City, Town, or Location of Death BALTIMORE	4c. County of Death
- A	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) Yrs.	Months Days Hours Min. 8. Date (Month 10 - 2)	of Birth h, Day, Year) b 1935 9. Birthplace (State or Foreign Country) SC
	aryland show	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc 20		10d. Inside City Limits 1 1 1 1 1 1 1 1 1
	r 28a-f	Director	MD NA BALTIMOR	10f. Zip Code	10g. Citizen of What Country?
	e 23a o	erai D	2915 KIRK AVENUE 11. Marrital Status 12. Was Decedent Ever in U.S. 13. V	21218	or No. 14. Race - American Indian,
920	hours after death with the Maryland tural, or Iteme 23a or 28a-f show at Examinat must be notified at	by Funerai	1 Never Married 2 Married 1 TYes 2 No	Was Decedent of Hispanic Origin? (Specify Yes if Yes, specify Cuban, Mexican, Puerto Rican, etc. I Personal No. Specify:	Black, White, etc. Specify: BLACK
Maryland 21215-0036	in 72 "nai	Completed	(Specify only highest grade completed) (Give	lent's Usual Occupation kind of work done during most of working OO NOT use retired)	16b. Kind of Business/Industry
d 21	Hyg the	e Con	12TH GRADE NA BUS 17. Father's Name (First, Middle, Last)	DRIVER 18. Mother's Name (First, M	MTA liddle, Maiden Sumame)
ylan	ed in p	To B	WILL WOODWARD		GERS
	12 h a 7 li		WILLIE P. WOODWARD, JR 6 LA	ig Address (Street and Number or Rural Route N NUREL PATH CT., WH	
Baltimore,	of of		20a. Method of Disposition 1	natory or other place)	BALTI MORE MD
Baltii	permit. Pag Depertment Intiportant: I any Injury o			Name and Address of Facility NGHN C. GREENE FUNE 151 BALTO NATU PIKE, B	
			23a. Part1. Ententible disease, or complications that caused the death. Do not entent shock, or heart failure. List only one cause on each line.		
ì	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. 3 2 N Dec+h		
	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	rationa /	5-1-41
	e be executed ysicien and e burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of);	Ensury / 1	52095
9760	ate be e hysicien the buria	cai	d.	and EDV	CALEXAMINER
Box/68	eath certificate be executed attending physicien and for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant 1□Live birth 2□Fetal death 3□	Ectopic pregnancy Other (specify)	23d. Date of delivery
P.O. B	at the deat by the att tached for	nysicia	in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown	Other (specify)	Month Day Year
	luires that n signed b	þ	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I. 23e.	Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
ital Records,	The law requires that the death certificat ate has been signed by the attending phy bage 2 should be detached for use as th	Completed		24a.	Was an autopsy findings available prior to completion of cause of death? Yas 2 No 1 Yes 2 No
Vital	ding Physicien: The I h. After this certificate ha funeral director, page	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check	only one)
n of	ng Phys Iter this neral di	on: To	1X Yes 227Ala 1 Nonpatient 2 ER/Outpatien 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 1 Natural investigation investigation	28c. Injury at 28d. Desc	Residence 6 □Other (Specify) cribe how injury occurred
Division of	To the Hospitel or Attending within 24 hours after death. To the Funeral Director; After completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, str.	eet, factory, office 28f, Loca	(Street and Number or Rural Route Number,
ž	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the		4 Homicide building, etc. (Specify) 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death	2915 H	Grickare Beltimore MI 21218
	the Hos in 24 ho the Fun	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or in and market stated.	vestigation, in my opinion, death occurred at the	time, date and place, and due to the cause(s)
	Towith	2	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	(h)		30. Name and address of person who completed cause of leath (Item 23a) (Type,	AT24389216 word 1165pite 1 MD	UCTEVET 6, ESPS
		ate	31. Date filed (Month, Day, Fear) 32. Registrar's Signature	monal Hospital, MD	
DH	Regist	3	NOV 0 3 2005		

ORIGINAL

NOV 0 7 2005

			1 - For State Registrar	State of M	laryland	-		of H	ealth a			giene Reg. No.	9		35742
	Physici /Medic Examin	cal	1. Decedent's Name (First, Middle 30 SEPH 4a. Facility Name (If not institution,	AMRHEIN			4b. City, 1	Town, or	Location o		2. Date of De Month OCTOBE	R 31	all county of D	ear 205	3. Time of Death 3:45 PM
	Funeral		,	LEOSPITAL 6. Sex 18 M 2 F	ge (In yrs. las	it birthday)	If Under Months		If Under 2 Hours	24 Hrs.	8. Date of Bir (Month, Da	th	BA 9.	LT 11 Birthpla Countr	
	Director		212-10-2624 Usual Residence of Decedent 10a. State 10b. County			Yrs. Town or Lo	cation				Jan 11,	1919) Ma	ryla 10	and d. Inside City Limits
	h the Mary or 28a-f ahe e notified a	irector	MD 10e. Street and Number		Balt	timore	10f. Zip	Code				10g. Citize	en of Wha	t Countr	1½ Yes 2 □ No y?
0-000-0	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f ahow other traumatic event, the Medical Examinar must be notified at	eted by Funeral Director	4501 Anntana Av 11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorced 15. Decedent (Specify only highes	12. Was Deceden Armed Forces ed 1 XYes 2 If Yes, Give Year or Dates	? 44–50	16a. Deced	f Yes, speci I ☐ Yes 2 tent's Usual	ent of Hisify Cubar	Specify:	, Puerto F		5	4. Race - A Black, V Specify: d of Busin	white, et	e. Ee
7170	filed within Hygiene. thar than " nt, the Mer	Completed	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, I	Callege (1-4or 5+	5+)		kind of wor DO NOT us trial		ineer	:	(First, Middle		ern]	Elec	tric
aryland	should be and Mental is marked or umatic eve	To Be	George Amrhein 19a. Informant's Name/Relationst			19b. Mailir	ng Address	(Street a	He1e	n Hu				te, Zip (Code)
поге, ма	Pages 1 and 2 nent of Health a int: If Item 27 is iry or other trai		Northwest Hosp: 20a. Method of Disposition 1 □ Burial 2 □ Cremation 4 ☎ Donation 5 □ Other (St	3 □Removal from State	20b. Plac	ce of Dispo	Old Co sition (Nam natory or oti	e of			dallsto ate		MD 21 ation - City		n, State
	permit. Pages Department of Important: If It any injury or o		21 Signature of Funeral Service I	icensee	rector		Name and tate A				655 W	. Bal	timor	e Si	treet
	Physician /Medical		3a. Pan1, Enter the disease, show, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. METAST		P	er the mode					rrest,		1	Approximate nterval Between Onset and Death
,007	certificate be executed the continuation and continuation and continuation are as the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter the arriving Cause (Disease or injury that initiated events resulting in death) Last	c	s a conseque										
O. DOX O	death certific e attending p d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal de	eath 3□	Ectopic pre					23	d. Date of Month		/ Pay Year
cords, P	w requires that the de been signed by the a should be detached t	by	Part II. Other significant condition	ns contributing to death	but not resulti	ing in the ur	nderlying ca	use give	n in Part I.			obacco use Yes 2 🗆			cause of death?
E L	The law ate has b page 2 si	Completed									24a. Was auto perfo		24b. Were prior deat	to com	sy findings available pletion of cause of
Vital	Physicism: The this certificate ral director, pag	o Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 X No	Hospital:	205	3/0-4		Othe			(Check only o				
0 00	Jing After fune	-	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investig			VOutpatien 8b. Time of Injury		c. Injury Work	4 🗀 (40)	2	ne 5 🗌 Resi 8d. Describe			Specify)	
DIVISION	e Hospital or Attandii 24 hours after death. e Funeral Diractor: A etely filled in by the fu	Certification:	3 Suicide 6 Could r 4 Homicide determi	ned 286. Place of II	njury - At hom tc. (Specify)	e, farm, str	eet, factory,	office		2	8f. Location (City or To		<i>Number</i> o	r Rural i	Route Number,
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in b	edical	(Check only 2 Medical I	g Physician: To the bes Examiner: On the basis and manners	of examination	edge, death n and/or inv	estigation,	in my op	inion, deat	h occurre	and due to the ed at the time,	date and p	lace, and	due to t	he cause(s)
	with To	Σ	29b. Signature and title of certifier	PHYSICIA					2723			29d. Date	R 3	1	2005.
			30. Name and address of person of AVVERALLALL 31. Date filed (Month, Day, Year)	HARI	SH		Print) N	0 PCT 401	HWE	S T (HOSOLI TIL VOC	TAL	CER	10	21133
DH	Sta Registr	rar	NOV 0 7	2005 Keen	trar's Signatur	Spe	de)								

DHMH 17 Rev 1/2001

		_1	For State Registrar Amend Item # 1. Decedent's Name (First, Middle, Last)	State of Ma	iryland	d / Dep	artment of H	lealth a Death	and Mental	Reg	2005	35743
	Physicia	an	1. Decedent's Name (First, Middle, Last) Dorothy Louise	Brown							Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City, Town, or	r Location of	Oct.	27	2005 4c. County of Dea	11:30 A
		Ship and	740 Poplar Grov	e Street	•		Balti				N/A	
	Funeral		5. Social Security Number 6. Sec	x 7. Age	92	i <i>st birthday</i> Yrs.	Months Oays	If Under Hours	Min. (Mon	of Birth th, Day, Y		thplace (State or Foreign buntry)
and the	Director	-	220-30-4058 Usual Residence of Decedent		92				Jan	. 14,	1913Was	n., D.C
	arylan show		10a. State 10b. County		10c. City,	Town or L	ocation					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	28a-f	ecto	Maryland N/A 10e. Street and Number			altin	nore			100	J. Citizen of What Co	
	with 1	급	740 Poplar Gro	ve St. A	pt. ﴿	SD- 5D	212	16			JSA	Suittry:
	death	Funeral Director	11. Marital Status	12. Was Decedent E Amed Forces?			. Was Decedent of H If Yes, specify Cuba	lispanic Ori	gin? (Specify Yes	or No-	14. Race - Ame Black, Whit	
36	or Ite	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 ☐ Yes 2 🔯 N If Yes, Give	lo		1 ☐ Yes 🎾 No	Specify:		,	Specify: B	
21215-0036	n 72 hours after death with the Maryland "netural", or Iteme 23a or 28a-f show colcal Exeminat be notified at	ted b	15. Decedent's Edu	Year or Dates:		16a. Dece	edent's Usual Occup	ation		16	6b. Kind of Business	/Industry
215	- 1 34	Completed	(Specify only highest grade Elementary/Secondary (0-12)	e completed) College (1-4or 5-	+)	life.	e kind of work done of DO NOT use retired	1)		F	Private	families
	70 75 15 15	S	8th grade 17. Father's Name (First, Middle, Last)			Hous	sekeeep H		er's Name (First, A			
Maryland	id be filed ental Hyg ked othe ic event,	m	Leonard Carter						zabeth			
ary	shoul and Mari amari umati	<u> </u>	19a. Informant's Name/Relationship (Ty	γρe, Print)		19b. Mail	ling Address (Street					Zip Code)
	ges 1 and 2 should t of Health and Men If Item 27 Is marke or other traumatic		Angela A. Robin	son	Jan. 31		and the second second	Aven				and 21211
Baltimore,	Pages 1 nent of H int: If Itel iry or oth		20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐ F		ce	metery, cre	position (Name of ematory or other place on Cemet	(e)	Date 11 / 4 / 0 5		oc. Location - City or	, Maryland
ij	in je artu		4 □ Donation 5 □ Other (Specify) 21. Signature of Buneral Service Licens		MC.							neral Home
Ba	Per Per Per Per Per Per Per Per Per Per		Demy for	le.					120000000000000000000000000000000000000			, Md 21215
			23a. Party. Enter the disease, or complement of the complement of	lications that caused ne cause on each lin	the death. ie.	. Do not er	nter the mode of dyin	ng, such as	cardiac or respira	tory arres		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Chr	UM	100	BEILL	14/1	1624	m	Man!	Onset and Death
46	Examiner	and the state of t		Oue to (or as a	a consequ	ence of):	. /		/	1/14	1960	
	7 =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	a conseque	ence of):				we	W	
	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	a conseque	ence of):						
60,	te be executed ysiclen and e burial-transit	calE		J 500 10 (0) 23 1	u 001130qu	G1100 01).						
	5 × 5			0.					***************************************		1	
Вох	death certificat e attending phy of for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth	2 Fetal	death 3	☐Ectopic pregnancy	/			23d. Oate of de Month	livery Day Year
0.	0 0 0	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐Unknown	time of de	ath 5	Other (specify)				WORK	Day 7 Sail
مَ	The law requires that fhe de ste has been signed by the a page 2 should be detached f	by Ph	Part II. Other significant conditions con	ntributing to death bu	ut not resy	Iting in the	underlying cause giv	en in Part I	. 23e	. Did toba	cco use contribute to	o the cause of death?
rds,	w requires been sign should be		HIREMIT)	100011	ONO.	11	TJ/1111	C		1 🗌 Yes	2 □No 3 1	robably 4 Unknown
Record	e law re has be je 2 sho	Completed	Medisty	131 M	Jest				24a	. Was an autopsy	24b. Were a prior to	utopsy findings available completion of cause of
									10	performe Yes 2	death? No 1 ☐ Yes	3 2 □ No
Vital	Physician: r this certific ral director,	To Be	25. Was case reterred to medical examiner?	Hospital: 1 □ Innatie	nt 2 TF	=B/Outnatie	ent 3 DOA Oth		of Death (Check		ce 6 Other (Spe	acity)
	ding Phy		27. Manner of Death	28a. Date of Injur (Month, Day		28b. Time Injury	of 28c. Injur				injury occurred	, and the second
Sior	eath or:	catlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				M 1 🗆	Yes 2				
Division		Certification:	4 Homicide determined	28e. Place of Inju- building, etc	ury - At hor c. (Specify,	me, tarm, s	treet, factory, office			or Town,	et and Number or R State)	ural Houte Number,
_	To the Hospital o within 24 hours aft To the Funeral D completely filled in		29a. Certifier 1 Certifying Phy	rsician: To the best of	of my know	vledge, dea	ath occurred at the tir	me, date ar	nd place, and due	to the cau	se(s) and manner a	s stated.
	the Houndary 124 the Fu	Medical	one)	iner: On the basis of and manner sta	examinati ited.	on and/or i			ath occurred at the			
	To To on	-	29b. Signature and title of certifier	Veran do	77		29c. Licens	a number	7	290	1. Date signed (Mgh.	Day, THAT)
2		1 3	11/W/V/1/A	WILL I'M		00.1.77.4	///3	10/0	χ		17/00	
11			30. If me and address of per out the 5	empleted cause of de	eath (Item	23a) (1ype	, Print/	/	1011	Z . 1 1	. 11	010.0
3			31. Date filed (Month, Day, Year)	mpleted cause of di	3//	111	ON WU	MI.	Rol D	1110	Mel	4218

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** AUDREY M. BOULDIN 2, NOV 2005 6:00P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner GENESIS HEALTHCARE CATONSVILLE CATONSVILLE
If Under 1 Year If Under 24 Hrs
Months Days Hours Min. BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2 □ Months Yrs. Director 58 12/20/1946 MARYLAND 219-50-2301 Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits is 1 and 2 should be filed within 72 hours after deeth with the Marylar of Heelith and Merial Hygiene. The firem 23a or 28a-1 ehow other treumatic event, the Medical Examinar must be notified at 1 X Yes 2 No Director MD N/ABALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2047 BEACHWOOD AVENUE 21207 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Š Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ACCOUNT MANAGER 12TH BANKING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be AUDREY NIXON ZELMA NIXON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SON 8832 TAMAR DRIVE, COLUMBIA, DANTE BENNETT MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1 Department of H Importent: If Iter any Injury or oth 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State METRO CREMATORY 11/07/05 CATONSVILLE, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 ral Service Licensee 4600 LIBERTY HEIGHTS AVE., BALTIMORE, the disease, or complications that caused the death, leart failure. List only one cause on each line. So not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Vause (Final Physician disease condition resulting in death) nonty /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. It is a leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner slcien and burial-transit Due to (or as a consequence of): attending physicien Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4☐Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 No 2∏ No 1 Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 1 Yes 2 No 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) a Hospitel or Attending Pl 24 hours after death. Funeral Director: After the 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospitel within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) RD. Caforgistle, Mg 1009 Frederick 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiege 15 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Henry E. Brent 10:45 AM NOVEMBER 6 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h City Town or Location of Death Examiner - BALTIMORE WASHINGTON MEDICAL CENTER BURNIE If Under 24 Hrs. HEUNDEL ANNE G LGN If Under 1 Year Birthplace (State or Foreign Country)
 VA Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ₹M 2 ☐ F Months Days Hours Min. 214-26-9454 87 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10h Count 10d. Inside City Limits If item 27 is marked other then "naturel", or items 23a or 28a-1 show or other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 107 Baltimore Ave Completed by Funeral 12. Was Decedent Ever in U.S. Agned Forces? 1 (A) Yes 2 □ No If ¥es, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced and Mental Hygiene. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lola Clark Robert Brent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) / Wife permit. Pages 1 and 2 Department of Health a Important: If item 27 is eny injury or other trai once. Rose Brent 107 Baltimore Ave, Glen Burnie, MD 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cometery, crematory or other place)
Crownsville Nat'l Cem 11-9-05 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville, MD 4 Donation 5 Other (Specify) 21. Sign vo e o Funeral Service L Fink Fundral Frome, P.A. 426 Crain Hwy, SW, Glen Burnie, MD 21061 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, may be cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or shock, or leart failure. List Immediate Cause (Final Muoca **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner anding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XXVo Day 4☐Pregnant at time of death 5 Other (specify) P.O. P been signed by the should be detached 9☐ Unknown 9 ☐ Unknowñ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause ol death? 24a. Was an certificate has b autopsy 2 No 1 ☐ Yes 1 ☐ Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2₩ No ē 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 ☐ Pending м 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of conties

1ARY A

31. Date filed (Month, Day, Year)

NOV 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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MD

32. Registrar's Signature

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	State of Maryland / Department of Health and Mental Hygiepe 05	35	74	į
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			For Stata Registrar	State of Marylan		tificate of L			leg. No.	33/40
	DE velet		1. Decedent's Name (First, Middle, Las	st)				2. Date of Dea Month	Day Yea	3. Time of Death
П	Physicia /Medic	_		ER LEE BOYD				Novembe		
	Examin	er	4a. Facility Name (If not institution, give 410 Main street A			46. City, Town, or Laure1	Location of Death		4c. County of De	George's
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign Country)
Ą.	Director	ļ	217-88-9416	¾ M 2□F 33	Yrs.	Months Days	Hours Min.	(Month, Day March 1		Maryland
	and		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Maryl	tor	MD Prince (George's I	Laurel					1 X Yes 2 ☐ No
	or 28e	lirec	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	ath wi	rai	410 Main Street,				20707		USA	in a to all an
	er de	une	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2/XNo	.S. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Black, W	merican Indian, hite, etc.
036	ors aft	by F	3 ☐ Widowed 4 🂢 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🂢 No	Specify:		Specify: T	White
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hyglene. Important: If item 27 ie marked other then "naturel", or items 23a or 28e-f ehow any fujury or other treumatic event, it a Madical Exertical must be notified at once.	Completed by Funeral Director	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of work	ung	16b. Kind of Busine	ss/industry
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lan,	Aental Aental rked tlc ev	To B	Francis Gregory	Boyd			Teres	sa A. Cl	evenger	
Maryland	and N le ma euma	•	19a. Informant's Name/Relationship (r, City or Town, State	e, Zip Code)
, S	fealth m 27		Teresa A. Cleveno			Main Stre			MD 20707 20c. Location - City	or Town State
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			23a. Part 1. Enter the disease, or com shock of heart failure. List only	plications that caused the deat one cause on each line.	th. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
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1	/Medical Examiner		1	Due to (or as a conseq	quence of):					
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Box	eath certi ettending for use a	ician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnature 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy			23d. Date of	
	0 0	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of o		Other (specify)			Month	Day Year
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	To the within 2 To the complet	Me	29b. Signature and title of certifier	Δ		29c. Licens	e number		29d. Date signed (M	onth, Day, Year)
			• //			0.0	.M.E.		November :	2, 2005
,			30. Name and address of person who	N/ 1,00.0	^ ^	111 Pe	nn Street	t Balti	more, Mar	yland 21201
	e ∴ E St	ate	31. Date filed (Month, Day, Year)	32 Registrar's Sign	ature	will			, , , , , , ,	,
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Registrar

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			1 = For Amend Item 201	State of Maryland / Depa b per fh G849 11-7-	artment of Health	h	2e0 0 5	35748
			Decedent's Name (First, Middle, Last))		2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Dorothea H	Burchill		Novembe	r 4, 2005	9:30AM
	Examin		4a. Fecility Name (If not institution, give		4b. City, Town, or Location		4c. County of Death	
			Future Care Ch		Reisters	town ar 24 Hrs. 8. Date of Birth	Baltimo	
	Funeral Director			7. Age (In yrs. last birthday) M XXXF 86 Yrs.	Months Days Hours	Min. (Month, Day,)	(ear) Cour	place (State or Foreign htry) nsylvania
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	ehow		10a. State 10b. County	10c. City, Town or Lo			1	0d. Inside City Limits 1 ☐ Yes XXNo
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Jor	it. Page ritment or ritant: M njury or		1 ☐ Burial XX Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, cre	matory`or other place)	11-8-05 11/5/05	•	
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Division of Vital Records,	or Atte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rura State)	al Route Number,
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	To the Hospital or Attending Physicien: within 24 hours effer death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	rsician: To the best of my knowledge, dea iner: On the basis of examination and/or in and manner stated.	th occurred at the time, date nvestigation, in my opinion, d	eath occurred at the time, dat	te and place, and due to	tated. the cause(s)
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)			WHO M	1	0/58	72 10	vense	4 2005
1			30. Name and address of person who	completed cause of death (Item 23a) (Type	, Print)	211	7/	,
) _		250	31. Date liled (Month, Day, Year)	32. Registrar's Signatura	199-57	-//-	0	
	Regist	ate rar	NOV 0 7 2	005 32. Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23a per Dr., G849, 11/0/05dhb Reg, No. 1 - For A State Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** RERRY 01.30 AM October 28 2005 Louise /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner CITY HOSPITAL BALTIMORE JOHNS HOPKINS If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Hours Days Months 1 M & F 218-28-3635 75 Dec 29, 1929 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Yes 2 No **Baltimore** Maryland N/A Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21217 U.S.A 2327 McCulloh Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No ff Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: ff Yes, Give Year or Dates: þ Specify: Black 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Coflege (1-4or 5+) Own Home Elementary/Secondary (0-12) Homemaker 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Walker William Small ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Maifing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2327 McCulloh Street Baltimore, Maryland 21217 Cornell Small 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/04/05 Brooklyn Park, Md. Cedar Hill Cemetery & Mausoleum 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Survice License 22. Name and Address of Facility Estep Brothers Funeral Service, P. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final HEART FAILURE disease or condition resulting in death) DAY Due to (or as a consequence of): 3 DAYS ATTACK HEART Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to (at as a consequence of). Examiner Coronary Artery Disease 2 vears that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 2 🔀 No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☑Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1⊠Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ertification: 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Physician /Medical Examiner The law requires that the death certificate be executed Records, P.O. Box 68760, has this certificate Division of Vital or Attending Physician: death.

attending physicien and for use as the burial-transit been signed by the should be detached I Director: After this d in by the funeral d

Funeral

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23s or 28a-f show any injury or other traumatic event, tra Medical Exeminal marke notified an once.

Baltimore, Maryland 21215-0036

To the Hospital within 24 hours. To the Funeral completely tilled	Olcoholl
Sta	te
Registr	a

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BANTAYEHU SILESHI 600 N 31. Date filed (Month, Day, Year)

NOV 0 7 2005

29b. Signature and title of certifier

29a Certifier

and manner stated

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES-000

BALTIMORE

29d. Date signed (Month, Day, Year)

October 28,2005

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death dent's Name (First, Middle, Last 3. Time of Death Year **Physician** 6: 60 A M NOVEMBER 2005 01 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALT IMORE 0F BALTIMORE SINAL HOLPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year) **Funeral** Months 1**X**M 2□ F Yrs. USUAL Residence of Decedent Director the Maryland 10a. State 10b. County 10c. City, Town or Location Inside City Limits 28a-f ehow traumatic event, the Madical Examiner must be notified at 1 Ses 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 Itema 23e Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2√ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 ō 1 Yes 2 No Specify. Divorced Year or Dates: 3 Widowed "natural", 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7: h and Mental Hygiene. 7 Is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Surf Last) Be ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City permit. Pages 1 and 2
Department of Heelth an Important: If Item 27 is many injury or other 7018. 60 MD 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Pemoval from State 4 □ Donation 5 □ Other (Specify) 23a. Part Enter the disease, of complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIOPULMONARY ARREST **Physician** disease or condition resulting in death) /Medical Examiner HEPATIC ENCEPHALOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed SEPTIL SHOLK the attending physicien and hed for use as the burial-tran Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ the funeral director, page 2 should be ALCOHOLIC LIVER DISEASE 1 Yes 2 No 3 Probably 4 Unknown Completed CIRRHOSIS OF LIVER 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) 24a. Was an 2 No FAX アルド 1 Yes Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2√ No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28d. Describe how injury occurred After Natural death. 1 Tyes 2 No investigation after death 2 Accident 6 Could not be determined 3 🗀 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 24 hours a 29a. Certifier 12 Certifying Physicien: To the best of my knowledge, death occurred at the fime, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) To the Vithin 2 and manner stated 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) 11/01/2005 D0061959 30. Nam and odress of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE AMAN SIBALI M.D. , SINAI HOSPITAL 31. Date filed (Month, Day, Year) NOV 0 7 Begistrar's Signature State Registrar

DHMH 17 Rev 1/2001

RODNEY

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygisps Reg. No. Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 736 RENSHAW 2005 7EORGE 4b. City, Town, or Location of Deeth 4c. County of Deeth Fecility Neme (If not institution, give street end number) BATIMORE MOSPITAL EXXY If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 1 Year Date of Birth (Month, Dey, Year) 6 Sex Birthplace (Stete or Foreign Country) Days Hours X M 2□F Months 214-62-8866 Yrs. 50 Md Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. Stete 10h County X□ Yes 2□ No Md. NA Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21239 USA 1925 Woodbourne Avenue 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Never Merried 2☐ Married 1 ☐ Yes 🎾 No Specify. Specify: Black 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction 10th grade Laborer 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Isabelle Crenshaw McDonald Dancey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 5655 Lothian Rd., Baltimore, Md. 21212 Franklin Crenshaw Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 SpBurial 2 ☐ Cremation 3 ☐ Removal from State Mt. Carmel Cem. 11-7-05 Dundalk, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Baltimore, Md. 21202 Laront M Thompse 1101 E. North Ave. March F.H. East Approximate Interval Between Onset end Death 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 54NW 2515 Due to (or es e consequence of) Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 1 Vas 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

ettending physician end for usa as the bunal-trensit

The law requires that the death certificate be executed

To the Hospital or Attending Physician: The law requires that the de within 24 hours efter deeth.

To the Funeral Director: After this certificate has been signed by the completaly filled in by the funeral director, paga 2 should be detached.

Examiner

Physician/Medical

δ

Completed

Be

Certification: To

Medical

State

Registrar

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Meryland Department of Health and Mentel Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Exempts.

Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

26. Place of Death (Check only one)

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Deeth

Inpatient 5 Pending investigation

Hospital:

2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

PLACE BACTIMONE, MO 21202

29a, Certifier (Check only one)

1 Naturel

2 Accident

3 Suicide

4 Homicide

1 Descripting Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es stated.
2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

29b. Signature end title of certifie Usty, MD

6 Could not be

29c. License number

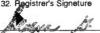
29d. Date signed (Month, Dey, Year)

me and address of person who completed cause of deeth (Item 23e) (Type, Print) ST PAUL 301

31. Dete filed (Month, Dey, Year)

32. Registrer's Signeture

2005



DHMH 16 Rev 6/95

		4	For State Registrar	e of Maryland / Depa <i>Cer</i>	irtment of Health and tificate of Death	d Mental Hygie Reg.		35752
	Physicia		Decedent's Name (First, Middle, Last)	Woodrow Wilson C	rawford	2. Date of Death Month November	Day Year 2, 2005	3. Time of Death
	/Medio Examin		4a. Facility Name (If not institution, give street a		4b. City, Town, or Location of Do		4c. County of Death	
	LAGIIIII	GI	Laurel Regional Hosp	ital	Laurel		Prince Ge	eorge
	Funeral		Social Security Number	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 H Months Days Hours M	Hrs. 8. Date of Birth (Month, Day, Ye	9. Birth	place (State or Foreign ntry)
	Director		216-18-1841 15XM 20	82 Yrs.	World Days Trouis IV	Feb 23,		ginia
	pu *	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
	Aaryla f sho	5	MD Prince Georg					1 ☑ Yes 2 ☐ No
	28a-	Director	10e. Street and Number	ge Laurer	10f. Zip Code	10g.	. Citizen of What Cou	intry?
	3a or	0	819 4th Street		20707		U.S.A.	
	death	nera	11 Marital Status 12. Was	s Decedent Ever in U.S. 13. Ved Forces?	Vas Decedent of Hispanic Origin? f Yes, specify Cuban, Mexican, Pu		14. Race - Ameri Black, White,	
21215-0036	within 72 hours after death with the Maryland one. then "natural", or items 23s or 28s-f show the Medical Evaminer must be ricitlized at	by Funeral	1 Never Married 2 Married 1 X	Yes 2 □ No	Tes, specify:	onto mean, etc.)	Specify: Whit	
Ö	72 ho	Completed	15. Decedent's Education (Specify only highest grade comp	(Give	lent's Usual Occupation	working 16t	b. Kind of Business/In	ndustry
2	ithin ithin	nple	Elementary/Secondary (0-12) Coll	ege (1-4or 5+)	kind of work done during most of DO NOT use retired)			
	filed w Hygier other th		17. Father's Name (First, Middle, Last)	Servi	ce Technician	Name (First, Middle, Mai	eating and	Cooling
Maryland	ouid be fi Mental H arkad ot atic ever	Be	Cleveland Crawford		15. Motiers	ivanie (First, Middle, Mai	Jen Sumame)	unknown
ž	d Me d Me mark matic	Jo	19a. Informant's Name/Relationship (Type, Prin	nt) 19b Mailir	ng Address (Street and Number of	r Rural Route Number C	ity or Town State. Zi	
<u>≅</u>	d 2 s th an traus				4th Street, Lau			
	s 1 and 2 in the strain of the strain 27 is other trau		20a. Method of Disposition	20b, Place of Dispo			c. Location - City or T	own, State
9	Pages ent of nt: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	from State	el Crematory No	v 4, 2005 O	denton, Ma	aryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be rediffed at once.		21. Signature of Funeral Service License	22 D	. Name and Address of Facility onaldson Funera	1 Home, P.A		
	_		23a. Part1. Enter the disease, or complications	that caused the death. Do not ent	13 Talbott Ave. er the mode of dying, such as care			Approximate
	Physician		shock, or heart failure. List only one caus				9	Interval Between Onset and Death
	/Medical		resulting in death)	irhosis of liver ue to (oras a consequence of):				over 3 years
	Examiner		Sequentially list conditions					
	φ #;	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ue to (or as a consequence of):				
	and -trans	Examiner	that initiated events	ue to (or as a consequence of):				
58760,	icate be executed physician and s the burial-transit	alE		20 10 (01 20 2 00100 0000 01).				
687		edical	d					
Box (death certific e attending pi id for use as t			es, outcome of pregnancy	Ter		23d. Date of deliv	very
_	0 0 0	Physician/M	in the past 12 months?	Pregnant at time of death 5]Ectopic pregnancy] Other (specify)		Month	Day Year
P.0	law requires that the de as been signed by the a 2 should be detached f	hys	9 Unknown	Unknown				
	es tha	by	Part II. Other significant conditions contributing		nderlying cause given in Part I.		co use contribute to t	
ord	w require been si should t	ted	Coronary artery disea	ase		_ Till Yes	2 No 3 Pro	bably 4 XUnknown
Records,	e law l has b	Completed				24a. Was an autopsy performed	prior to co	opsy findings available empletion of cause of
E H	Th ate pag	Sor				1 ☐ Yes 2 🔀		2 No
Vital	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner? Hospital		Othor	Death (Check only one)		
of	Phys this al din	.To	I Tes ZX No	1 XInpatient 2 ☐ ER/Outpatier Date of Injury 28b. Time o	IL 3 DOA 4 INUISII	ng Home 5 ☐ Residence 28d. Describe how		fy)
O	ding h. After fune	tion	1 X Natural 5 Pending 2 Accident Investigation	(Month, Day Year) Injury	f 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	ļi.	,,	
Division	Attending r death.	fica	3 ☐ Suicide 6 ☐ Could not be 28e.	Place of Injury - At home, farm, str	eet, factory, office	28f. Location (Stree	at and Number or Rur	ral Route Number,
ă	s after	Certification:	4 Homicide	building, etc. (Specify)		City or Town, S	itate)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	dical	(Check only 2 Medical Examiner: Or	To the best of my knowledge, death the basis of examination and/or in d manner stated.				
	To the within 2 To the complet	Me	29b. Signature and title of certifier	AR	29c. License number	29d.	. Date signed (Month,	, Day, Year)
			1	100 - W. A	D24721	No	ovember 3,	2005
4			30. Name and address of person who complete Syed Sadig, M.D. 1	d cause of death (Item 23a) (Type,		Maryland 2	0708	
	Sta	ate				nary rana z	3,00	
	Regist		NOV 0 7 2005	32. Registrar's Signature				

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryland / Dep	partment of Health and ertificate of Death	Mental Hygie	2000	35753
			Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physicia /Medic		SHERRY	ADELE C	OHEN	NOVEMBER	3 2005	8:30 A M
	Examin		4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or Location of Deat	h	4c. County of Death	
			ATRIUM VILLAGE		OWINGS MILLS		BALTIMO	RE
ŀ	Funeral Director		111 10 / 0 11	7. Age (In yrs. last birthda) 7. Age (In yrs. last birthda) 7. Age (In yrs. last birthda)	/ If Under 1 Year If Under 24 Hrs Months Days Hours Min.		9. Birtho 926	lace (State or Foreign htry) NY
	land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	ocation		1	0d. Inside City Limits
	Mary I sh	to	MD BALT	TIMORE OW:	NGS MILLS			1 ☐ Yes 2 🎇 No
	r 28e	Director	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Cour	ntry?
	th wit		4730 ATRIUM COUP	RT	21117			USA
	ems - dea	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White,	
36	or la	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ሺ No If Yes, Give	1 ☐ Yes 2 No Specify:		Specify:	WHITE
Ö	within 72 hours after death with the Maryland one. Then "naturel", or Items 23a or 28a-f show he Madical Examinar must be notified at	d be	15. Decedent's Edu	Year or Dates:	edent's Usual Occupation	16	b. Kind of Business/In	duetry
5	in 72	Completed	(Specify only highest grade	a completed) (Giv	re kind of work done during most of wo DO NOT use retired)	rking	b. Kind of business in	dustry
212	y with	E	Elementary/Secondary (0-12)	College (1-4or 5+) ACCOL	JNTANT		GOVERNMENT	
פ	e filed at Hygi other vent,	Bec	17. Father's Name (First, Middle, Last)		18. Mother's Na	me (First, Middle, Ma	iden Sumame)	
<u>a</u>	2 should be filed within 72 hours after death with the Marylan and Manth Hygiens is and water Hygiens is marked other then "naturel," or items 23a or 28a-f show as marked other then "naturel," or items 23a or 28a-f show as marked other than Marylan Examiner mant be notified at	10	HARRY	LEV	/IN CLARA			STARK
Maryland 21215-0036	s 1 and 2 should if Health and Mer Item 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty		ling Address (Street and Number or R			Code)
2	t and tealth im 27		MICHELLE HOROWI	76. DAUGHTER 76.	BO MIDTOWN ROAD -			
altimore,	Peges 1 nent of H int: if ite iry or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🌣 R	emoval from State cemetery, ci	ematory or other place)		c. Location - City or To	
<u>=</u>	it. Per rtmer rtent njury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Liçensi		DAVID CEMETERY 11 22. Name and Address of Facility			-
Ba	permit. Peges 1 an Department of Heal Importent: If Item 2 any Injury or other once.		21. Signature of Purietal Service Licens	7 >			ON & BROS.	, INC. MD 21208
			23a. Part1. Enter the disease, or compli	cations that caused the death. Do not e	8900 REISTERSTOWN nter the mode of dying, such as cardia			Approximate
	Physician		shock, or heart failure. List only or Immediate Cause (Final		: Cardiovascular	- diserio		Interval Between Onset and Death
7	/Medical		disease or condition resulting in death)	Due to (or as a consequence of):	- Caratorascular	artase		
	Examiner		Sequentially list conditions,).				
	p #	iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):				
	and and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):				
8760,	cete be executed physician and the burial-transit	品田田						
687	tificete og phys as the	edicai						
Box	eath certific attending p for use as	Ž	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy	D4 - S7010-5		23d. Date of delive	ary
Ď.	that the death cer ed by the attendin deteched for use	Physician/Me	in the past 12 mounts? 1 ☐ Yes 2 ☑ No	4☐Pregnant at time of death 5	☐Ectopic pregnancy ☐ Other (specify)		Month	Day Year
P.O.	at the by th	hys	9 ☐ Unknown	9□ Unknown				
	ed Ped	ρ	Part II. Other significant conditions cor	ntributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to the	
Division of Vital Records,	w requir been si should	Completed		<u></u>		1 L Yes	2 No 3 Prot	pably 4 JUKnown
ec	e 2 sl	npie				24a. Was an autopsy	24b Were auto	psy findings available mpletion of cause of
<u> </u>	cete					performe 1 □ Yes 2 □	d? death? ONo 1 ☐ Yes	2□ No
<u>≅</u>	ician certifi rector	Be	25. Was case referred medical examiner?	lospital:	Other	ath (Check only one)		
ō	Phys rthis raldii	- L	1 Yes 2 No	1 ☐ Inpatient 2 ☐ ER/Outpat 28a. Date of Injury 28b. Time	ent 3 DOA 4 Vinursing	Home 5 Resident	ce 6 □Other (Specif	(y)
Ö	ding th: Afte	tion	1 atural 5 Pending 2 Accident investigation	(Month, Day Year) Injury			,,	
/isi	Attendi	ifica	3 Suicide 6 Could not be	28e. Place of Injury - At home, farm,			et and Number or Rura	al Route Number,
á	s effer s effer al Dire	Certification;	4 Homicide	building, etc. (Specify)		City or Town,	State)	
	To the Hospitel or Attending Physician: The law within 24 hours elfer death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical (sician: To the best of my knowledge, de ner: On the basis of examination and/or				
	the F the F the F	Medi	one)	and manner stated.				
	To To	2	29b. Signature and title of certifier MALAMANA	oMIO.	29c. License number D 00 5746		I. Date signed (Month,	uay, Year)
	4		1001-1				11/3/05	
0			30. Name and address of person who or	ompleted cause of death (Item 23a) (Typper Completed Cause MD To To To To To To To To To To To To To	e, Print) 20 Park Heights.	Avenue 1	Baltimore. A	80512. CI
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	M. A		10.07	
	Regist		NOV 0 7 2005	Kan I Book				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15 1 - For Stata Ragistrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year THOMAS DANIEL D'AMICO, JR. NOVEMBER 2005 1000 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1220 KENWOOD RD GLEN BURNIE ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 F Yrs. 216.18.9368 80 MAR 5, 1925 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1220 KENWOOD RD 21060 USA 12. Was Decedent Ever in U.S. Armed Forces? YYZ Yes 2 ☐ No ITYes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2000 Married 1 Yes XX No Specify 3 Widowed 4 Divorced Year or Dates: WWII WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 WELDER/STAFF REP IUMSWA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) TOMMASO D. D'AMICO, SR. ANNA NAZZARO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CATHERINE M. D'AMICO 1220 KENWOOD RD GLEN BURNIE, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MEADOWRIDGE CEM 11.4.2005 ELKRIDGE, MD 21. Signature of Funeral Service License 22. Name and Address of Facility
FINK FUNERAL HOME, P.A. GREGORY FINK MO1148 426 CRAIN HWY SW GLEN BURNIE, MD 21061 enter the dise se, r or heart failure. List on ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Immediate Causa (Final avenna Metasla disease or condition resulting in death) Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day

Physician /Medical Examiner

burial-

as the

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Completed by

Be

Certification: To

Medical

State

Registrar

signed by

certificate

: After or Attending

Director:

within 24 hours a

death.

filled in by the funeral director.

attending physician

The law requires that the death certificate be executed

of Vital Records,

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

Funeral

Director

item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Expressional by excitited at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene important: if item 27 is marked other than any injury or other traumatic event, the Magang Jongs.

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner Physician/Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

4☐Pregnant at time of death 9 Unknown

sheter

5 ☐ Other (specify)

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. saltu mean

24a. Was an autopsy performed 1 Yes

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Besidence 6 Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical 1 ☐ Yes 2 ☐ No 27. Manner of Death

Date of Injury (Month, Day Year) 5 Pending investigation

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State)

2 Z No

28d. Describe how injury occurred

29a. Certifier

1 TiMatural

2 Accident

3 ☐ Suicide

4 \ Homicide

1 Dertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and two of certified

30. Name and address of person who completed cau

6 Could not be

determined

dup Doeler

of death (Item 23a) (Type, Print 8021 KITCHIS

29c. License number

29d. Date signed (Month, Day, Year) 2005

C-V. CYRIAC-M.D 31. Date filed (Month, Day, Year)

32. Registrar's Signature

NOV 0

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State	of Marylar	nd / Depa <i>Cel</i>	artment of F rtificate of I	lealth ar Death	nd Mental Hy		005	35755
			Decedent's Name (First, Middle,	Last)					2. Date of De			3. Time of Death
	Physicia /Medic		DOROTH	4	Dou	JELL			Octobe	Day	2005	04:45AM
ş	Examin		4a. Facility Name (If not institution,	give street and nu	imber)		4b. City, Town, o		Death	4c. 0	County of Deat	1
			Harbor Ho	spital	Cento	<u>_</u>		IMOre If Under 24	l Her		N/A	
	Funeral Director			6. Sex 1 □ M 2 SyF	7. Age (In yrs. 84	Yrs.	If Under 1 Year Months Days		Min. (Month, Da	y, Year)	Co	nplace (State or Foreign untry)
			219-05-6681 Usual Residence of Decedent		04				Nov. 4	, 192	0 Mar	yland
	nyland how		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					10d. Inside City Limits
	Be-f e	cto		timore		Baltim	ore					1 ☐ Yes 2X No
	a or 2	Die	10e. Street and Number				10f. Zip Code	22		-	en of What Co	untry?
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Iteme 23a or 28e-f ehow int, the Macical Examiner must be natified at	Funeral Director	916 Palladi Dri		cedent Ever in U	IS 13 1	212		n? (Specify Yes or No	US	4. Race - Ame	ican Indian
	riten riten	Fun	1 Never Married 2 Marrie	Armed F ed 1 ☐ Yes	orces? 2t☑No		f Yes, specify Cuba	in, Mexican, I	Puerto Rican, etc.)		Black, White	
3	ral', o	by	3 ₩Widowed 4 ☐ Divorced	If Yes, G Year or I	IV6 ~ _		1 ☐ Yes 2X No	Specify:			Specify:	White
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7	within ane. then	mp	Elementary/Secondary (0-12)		(1-4or 5+)		Door i do			Do	mled no	
N 5	Hygie Hygie ther ont.		12 17. Father's Name (First, Middle, L	ast)		vice	Presider		s Name (First, Middle		nking Sumame)	
0	should be filed within and Mental Hygiene. Thanked other then imatic event. Its Mental in the Mental count.	To Be	Unk		Jo	hnson		Unk	,		,	
2	w = = 3	-	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	ng Address (Street	and Number	or Rural Route Numb	er, City or	Town, State, 2	ip Code)
<u>.</u>	and 2 lealth a m 27 is		Susan E. Consta	nt / God-				Drive,	Baltimore			
20	Pages 1 nent of He int: if iten		20a. Method of Disposition 1 ☐ Burial 2 【Cremation	3 □Removal from	1	Place of Dispo cemetery, crer	sition (Name of matory or other place		Date		ation - City or	
	t. Partmentment:		4 Donation 5 Other (Sp	ecify)	Ba		Crematory		0/29/05		•	Maryland
0	permit. Pages Department of I Importent: If Ite eny injury or of		21. Signature of Funeral Service L	icensee	· Q.				Hubbard F enue, Balt			
			23a. Part1. Enter the disease, or o	complications that	caused the dea						, ricit y	Approximate
	Physician		shock, or heart failure. List of Immediate Cause (Final	nly one cause on	each line.	200.						Interval Between Onset and Death
į	/Medical		disease or condition resulting in death)	aDue to	(or as a conse		\$					9 days
	Examiner		Sequentially list conditions.	b	E	4 0000	arditi	S				
7	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conse	quence of):						
V -	be execut iclan and burial-trar	xan	that initiated events resulting in death) Last	c	(or as a conse	quence of);						
	icate be executed physiclan and s tha burial-transit	dicai	8	d								
00			IC COMME									
Š	th certendir	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		utcome of pregn birth 2 Fet		DEctopic pregnancy	,		23	3d. Date of deli	•
5	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4⊟Preg 9⊟Unki	nant at time of	death 5□	Other (specify)				Month	Day Year
	that the		Part II. Other significant condition	s contributing to	death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco us	e contribute to	the cause of death?
cords,	urres r sign	d by	Duode	nal (Unei	ode	inta sia			Yes 2□		obably 4 donknown
3	s beer	Completed	Chron	in pla	Show	ture	Quilans	2000	\$20 0 24a. Was	an	24b. Were au	topsy findings available
ב	sician: The law s certificate has t irector, page 2 s	mo	Deah	ato o	10000	iture	2	rayo	perfo	psy ormed? 2 No	death?	topsy findings available completion of cause of
	ian: rtifica ctor, p	BeC	25. Was case referred to medical examiner?	eus	VV		۵	26. Place o	1 ☐ Yes		10 105	215 110
5	hysic his ce	70	1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	ER/Outpatier		er: 4 🗆 Nurs	sing Home 5 ☐ Resi	dence 6	Other (Spec	ufy)
	ing P	lon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending		of Injury nth, Day Year)	28b. Time of Injury	Wor		28d. Describe	how injury	occurred	
DIVISION	death ctor: , the f	icat	2 Accident investig	ot be	of Injury . At h	nome farm et	M 1 □	Yes 2 □ No		Street and	Number or Pu	ral Route Number,
2	after after Dire	Certification:	4 ☐ Homicide determine	build	ding, etc. (Spec	ify)	eet, lactory, onice		City or To	wn, State)	TABINDER OF THE	rai noute teamber,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 1 Certifying	Physician: To th	e best of my kn	owledge, deat	h occurred at the tir	ne, date and	place, and due to the	cause(s) a	and manner as	stated.
	the Hin 24 the Fu	Medical	one) 2 Medical E	xeminer: On the	basis of examin nner stated.	ation and/or in	vestigation, in my o	pinion, death	occurred at the time,	date and	place, and due	to the cause(s)
	To To I	Σ	29b. Signature and title of certifier				29c. Licens				signed (Monti	
L					du.		K	CESOC	100	Uct	ODER 28	5,2005
	ID		30. Name and address of person v	the completed cau	ise of death (Ite	m 23a) (Type,	Print)	3001 (x	ruth Hanore	c.St.	not Rall	14.1.5C2 14.1.
	Sta	at <u>e</u>	31. Date filed (Month, Day, Year)	32	Registrar's Sign	ature	Janua,	,	-01.1.1.	- 0 144	er, Daly	UM, DIOM
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DHMH 17 Rev 1/2001

		-	For State Registrar	tate of Maryland	d / Depa <i>Cer</i>	artmei <i>tifica</i>	nt of He te of D	ealth and <i>eath</i>	Mental H	ygiene Reg. No.	005	35756
1	35	£	Decedent's Name (First, Middle, Last)						2. Date of I	Death	Vana	3. Time of Death
	Physicia /Medic		Edmund J. Dowling						Month	/ O1		8835 PM
1	Examin		4a. Facility Name (If not institution, give street			4b. City		ocation of Dea		4c.	County of Death	1
- 1		- - •	ngA.72	es			Ba	Atimor	·e_			/a
	Funeral Director		5. Social Security Number 6. Sex 15 M		ast birthday) Yrs.	If Unde Months	Days	If Under 24 Hr Hours Mir		Birth Day, Year) 1, 192		nplace (State or Foreign untry) Yland
	D .		Usual Residence of Decedent	140.00								
	arylar show	_	10a. State 10b. County	Toc. City	, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2X No
	8a-f	cto	Maryland Baltimore		Balt	imor				10 000		
	vith th	Dire	10e. Street and Number	-		101. 2	p Code	24.220			zen of What Co	•
	e 23g	rai	1028 Elmridge Avenue		C 12.1	Man Daw	doct of His	21229	Chaoifu Van ar l	1	United	
21215-0036	be filed within 72 hours after death with the Maryland ald Hygiene. Id other than "natural", or iteme 23a or 28a-f ehow odher than "natural", or iteme 23a or 28a-f ehow event, the Madical Examinating must be notified.	by Funeral Director	1 ☐ Never Married 2 💥 Married	Was Decedent Ever in U. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates:		f Yes, sp		Specify:	Specify Yes or I into Rican, etc.)		Black, White	
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P	e filed al Hygi l other vent, L	Be	17. Father's Name (First, Middle, Last)						ame (First, Midd		Sumame)	
<u>la</u>	should be ind Mental I	70 6	Howard Dowling					Cathe	erine Do	re		
Maryland	and and mem		19a. Informant's Name/Relationship (Type,		1						r Town, State, Z	
	1 and 2 Health sem 27		Helen B. Dowling /							_	Marylan	
Baltimore,	of Head of Hea		20a. Method of Disposition 1 □ Cremation 3 □ Remo	20b. P	lace of Dispo emetery, cren	sition (Na natory or	ame of other place)	Date	20c. Lo	cation - City or	Town, State
Ē	permit. Pages. Department of I Important: If its eny injury or of		4 □ Donation 5 □ Other (Specify)		Cathe	dral	Ceme	tery 11	/5/2005	Balt	inore,	Maryland
at	Departi Departi Import eny inj		21. Signature o Funeral Service Licensee	. 0	22	. Name a	ind Address	of Facility Hu	ibbard F	unera	l Home,	Inc.
-	205 2	5 7		mal	4	107	Wilke	ns Aver	nue, Bal	timor	e, Mary	land 21229
Ä,			23a. Part1. Error the disease, or complication shock, or heart failure. List only one complications are complicated to the complex of the com	ons that caused the death ause on each line.	n. Do not ent	er the mo	de of dying	, such as cardi	ac or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Ĺ		cm	15	cility		nonia		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of);			-	1			
	Examine		Sequentially list conditions, if any, leading to immediate	C	ongestin	رو	hear	+ fai	lure			
T	pe sit	Examiner	cause. Enter Underlying	Due to (or as a consequ	ience of):		4					
V	and I-tran	хап	Cause (Disease or injury that initiated events c resulting in death) Last	Due to (or as a consequ	oren ence of):	IN	teg	diseas	C			
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387		dical	d	Cereo	TOVASC.	alw.	acc	· acce	201111		· aca · we	uk ress
	death certific e attending p od for use as	1 W 1	IF FEMALE: 23c.	If yes, outcome of pregna	ncy						23d. Date of deli	verv
Вох	atter I for u	Physician/M	in the past 12 months?	1 Live birth 2 Fetal	death 3	Ectopic Other (s	pregnancy specify)				Month	Day Year
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٥.	res that signed by be deta		Part II. Other significant conditions contrib	outing to death but not resi	ulting in the u	nderlying	cause give	n in Part I.	23e. Di	d tobacco u	se contribute to	the cause of death?
sp.	uires Id be	d by	Hypertersion						1(Yes 2	□No 3 □ Pro	bably 4. Unknown
S	w require been si should b	iete	00.00						24a. W	as an	24b. Were au	topsy findings available
Division of Vital Records,	The law requires that the sete has been signed by the page 2 should be detache	Completed	percent						pe	topsy normed?	death?	topsy findings available ompletion of cause of
la		Ö	25. Was case referred to medical					26 Place of D	eath Check onl	2 No	1 L Yes	2 □ No
5	Physician: this certific ral director,	ToB	examiner? 1 Tes 2 No Hosp	oital:	ER/Outpatier	nt 3 🗆 🖸	Othe	r			3 □Other (Spec	who)
o			27. Manner of Death	28a. Date of Injury	28b. Time o		28c. Injury Work		28d. Describ			"")
Ö	Attending I or death. ector: After by the funer	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	М		r es 2 □ No				
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3	Sta Registi		31. Date filed (Month, Day, Year) NOV 0 7 2005	32 ARegistrar's Signa	ture	and to						

			For State Registrar		of Maryland	d / Dep		t of H	ealth a	and M	ental Hyg	iene 0) 5	357	57
	Physici	_ S ₁	Decedent's Name (First, Midd)	e, Last) LILLIE	ELAINE	DAV	'IS			N	2. Date of Deal		2885	3. Time of E	
No. of the second	/Medio	14.	4a. Facility Name (If not institution Saint Jose;	n, give street and nu oh Medic	al Cent	er.	4b. City,	Town, or	Location	of Death OWS 0	n	4c. County	y of Death Balt	imore	
· · ·	Funeral Director		5. Social Security Number 220-20-3913	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs. la	ast birthday, Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, May 30,	Year) 1928	Cou	place (State or ntry) yland	Foreign
	aryland show	_	Usual Residence of Decedent 10a. State 10b. County			, Town or L				-				10d. Inside City	
	the Mark	ecto	MD Balt:	imore		imoniu	Jm 10f. Zip	Code			1	0g. Citizen of	What Cou		
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036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic avant, the Madical Examinar must be notified at ance.	by Funeral Director	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	ned 1 ☐ Yes	2 (X)No ive	S. 13.	Was Deced If Yes, spec		spanic Ori n, Mexicar Specify:		ecify Yes or No- Rican, etc.)	Bla	ce - Americk, White		
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Man	d 2 sho th and 7 is mu trauma		19a. Informant's Name/Relations Dale Schnepf/				-				al Route Number 5 Mills,	-		о Соde) 21117	
ē,	is 1 an of Heal tem 2 other		20a. Method of Disposition		20b. Pl.	ace of Disp ametery, cre			e)		Date	20c. Location			
Baltimore,	Page ment c tant: If		1 X Burial 2 □ Cremation 4 □ Donation 5 □ Other (S	Specify)		relan	₫ Mem.	. Par	rk		/2005			, Maryla	
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	Physician		23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition		caused the death each line.		ITEST			cardiac c	or respiratory arr	est,		Approximate Interval Betw Onset and Di DAYS	reen
	/Medical Examiner		resulting in death)		(or as a consequ IGESTIVE		ART F	AIL	JRE					YEARS	3
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,092	te be executed ysician and e burial-transit	cai Exa	resulting in death) Last	c. Due to	(or as a consequ	ence of):									
68	rtificate ng phy as the		IE ECMAI E.	u											
.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	1 ☐ Live	utcome of pregnar birth 2 Petal gnant at time of de nown	death 3	⊒Ectopic pi ⊒ Other (sp						ate of deliv		ear
<u>α</u>	w requires that been signed b should be deta		Part II. Other significant conditi	ons contributing to o	death but not resu	alting in the	underlying	ause give	en in Part I	l.	23e. Did tol	V		he cause of de bably 4 ∐Ur	
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Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medica examiner? 1 Yes 2 No	Hospital:	In-ationt 200	ER/Outpatie	ent 3⊡ DO	Othe	20		n <i>(Check</i> on <i>ly</i> on me 5□ Reside		(C	4.3	
Division of	Attending Physic death. actor: After this by the funeral did	ition: To	27. Manner of D ath 1 Natural 5 ☐ Pendi	28a. Diffe	-	28b. Time of Injury		28c. Injun Worl	4 🗆 141		28d. Describe ho			iy)	
Divis	al or Atter after dea Director d in by the	Certification:	3 Suicide 6 Could 4 Homicide deten	nined 288. Plac	e of Injury - At ho ding, etc. (Specify		treet, factor	y, office			281. Location (Si City or Town		ber or Rur	al Route Numb	9θΓ,
	To the Hospital or Attending Phymitin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical C		ng Physicien: To th Examiner: On the and mai											
)	To the within 2 To the complet	M	29b. Signature and title at entific	Helay,	MA		29		e number 7695	;	/	9d. Date signe	ed (Month, rber	Day, Year) 3, 200	05
13	19		30. Name and address of person	who completed cau			, Print)	R D	RIVE	TO		1ARYLA			
		ate	31. Date filed (Month, Day, Year					4 6 7 Auf	a year T Rees	v e 1007 V	- www.mar. 1 ag . 5				
- A.	Regist	rar	HOV 0 77	005	P 18.	A STATE OF THE PARTY OF THE PAR									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 5

Certificate of Death

			1 - For State Registrar	State of N	Maryland /	Depar Certi	tment of I ificate of	lealth ar Death	nd Me	ntal Hy	/giene Reg. No		3	575	58
	Physici	an	Decedent's Name (First, Middle, L.						Ł.,	. Date of De Month		. Ye	ar	3. Time of	
	/Media			Davison						ovembe		Ž, 20Ď		3:05	5 p M
	Examir	ner	4a. Facility Name (If not institution, gi	ve street and numbe	r)		4b. City, Town,		Death		40	County of l			
			Dak Crest 5. Social Security Number 6.	Sex 7. A	Age (In yrs. last i	hirth day)	Parkvi		4 Hrs. To	Data of Bi	rth	Balt			C i
	Funeral Director			1⊠M 2□F	B7		Months Days		Min.	Date of Bi (Month, D	av. Year, 5, 1	918	Countr	ce (State o	ir r-oreign
			Usual Residence of Decedent		<u> </u>					uy. I	٠, ١	710	UKJ	Lahoma	3
	ylan		10a. State 10b. County		10c. City, To	own or Loca	ition						10	d. Inside Ci	ity Limits
	Mar 9-f st	5	Md. Baltim	ore	Parkv	/ille								1 🖺 Yes	2 [▼No
	h the	Director	10e. Street and Number	-			10f. Zip Code				10g. Ci	tizen of Wha	t Counti	ry?	
	th wil	a D	8810 Walther B	lvd.				21 2 34					US	SA	
	72 hours after death with the Maryland natural', or items 23a or 28e-f show likal Ezaminat must be notified at	by Funeral	11. Marital Status	12. Was Deceder Armed Forces		13. Wa	as Decedent of I	Hispanic Origi	n? (Specif	y Yes or N	0-	14. Race - A			
36	or it	F.	1 ☐ Never Married 2 ☑ Married	1 Ves 2	□No	1	Yes 2√2 No			, 0.0.,		Specify:			
215-0036	ural';	d b	3 Widowed 4 Divorced	Year or Dates	3;								Whi		
15	"nat	Completed	15. Decedent's E (Specify only highest g		16	6a. Deceder Give kit life DC	nt's Usual Occu nd of work done O NOT use retire	pation during most o	of working		16b. K	(ind of Busin	ess/Indu	ıstry	
212	within ene. than "	μĔ	Elementary/Secondary (0-12)	College (1-40			Imployed					CPA			
	filed Hygi othar		17. Father's Name (First, Middle, Las		7	JCT! L	-IIIPTOYEC	18. Mother's	s Name (F	First, Middle	e, Maider				
lan	ld be ental kad c	To Be	Frank Davison					Ethe	1 B:	ray					
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28e-f show then traumatic evant, the Medical Examinar must be notified at	-	19a. Informant's Name/Relationship	(Type, Print)	15	9b. Mailing	Address (Stree	and Number	or Rural F	Route Numb	oer, City	or Town, Sta	te, Zip C	Code)	
	permit. Pages 1 and 2 sho Department of Health and Important: If itam 27 Is m any injury or other traum 20068.	1	Mrs. Frances Davi	son/ Wife		8810	Walther	Blvd.	Park	kville	e, Mo	d. 212	34		
J.e	of He of He litam		20a. Method of Disposition	70	como	of Disposit	tion (Name of tory or other pla	ice)	Dat	8	20c. L	ocation - Cit	or Tow	n, State	
Baltimore,	Pages nent of I ant: If its ury or o		1 ☐ Burial 2 ☑ Cremation 3 '4 ☐ Donation 5 ☐ Other (Spec		(0		ervice C		-4-05	5	Tot	uson,	Md.		
alt	permit. Pa Departmer Important any injury QUCE.		21. Signature of Funeral Service Lice	engee (22. 1	Name and Addre	ess of Facility		Llens	. Т.				
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			23a. Part1. Enter the disease, of cor shock, or heart failure. List only	nplicetions that caus y one cause on each	ed the death. D						arrest,		1	Approximatentel	ween
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68	ificate g phy as the			d											
Box	nding use a	\Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregnancy							23d. Date of	deliven	,	
	death e atte	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant	2 Fetal dea at time of death		ctopic pregnand Other (s <i>pecify</i>) _	y 				Month	C	Day 1	Year
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	w requires that been signed to should be deta	by P	Part II. Other significant conditions	contributing to death	but not resulting	g in the und	erlying cause gr	ven in Part I.		23e. Did	tobacco	use contribu	e to the	cause of d	eath?
ord	equir en si ould I	ted							_	10	Yes 2	□No 3[] Probal	bly 4 🗖	<u>In</u> known
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п	ding Phys After this funeral di	on	27. Manner of Death 1 Aatural 5 Pending	28a. Date of Ir (Month, L	njury 28b Da <i>y Year)</i>	D. Time of Injury	28c. Inju Wo			1. Describe	how inju	ry occurred			
Sio	Attanding r death. actor: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not	he	4.6			Yes 2 □No							
Division of Vital Records,	or Al after of Dirac in by	Certification;	4 Homicide determine	286. Place of I	Injury - At home, etc. <i>(Specify)</i>	, tarm, stree	t, factory, office		281	City or To	(Street ar wn, State	nd Number o a)	r Rural i	Route Num	ber,
	spital ours a		29a. Certifier 1 Certifying F	hysician: To the be	st of my knowled	fre death a	occurred at the t	me date and	place and	due te #-	02::0-/	\ and =	r an ct.	and .	
	To the Hospital or Attanding Physicien: The i within 24 hours after death. To tha Funarel Diractor: After this certificate his completely filled in by the funeral director, page	edical	(Check only 2 Medical Exa	miner: On the basis and manner	of examination	and/or inves	stigation, in my	opinion, death	occurred	at the time,	date an	d place, and	due to t	he cause(s)
	Fo th Fo th compl	Me	29b. Signature and title of certifier	mo			29c. Licen:	se number			29d. Da	te signed (M	onth, D		
	0		1				Dr	3115			N	vemb	. 3	10 2	00/
	IT		30. Name and address of person who	completed cause of	f death (Item 23a	a) (Type, Pr			4						
7			Jeff Londs			ia 1 th	w BI	- 0	Pa k	ille	M	021:	3 '	7	
	Sta	ate	31. Date filed (Month, Day, Year)	20	strar's Signature	A COL									

State of Maryland / Department of Health and Mental Hygien 1 15 35759 For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** October 29, 1:27 PMM 2005 Mary B. Davis /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Harford Gardens If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 💢 F May 20, 1920 Director 215-03-2324 85 Maryland Usual Residence of Decedent with the Maryland Od. Inside City Limits 10c. City, Town or Location 10a, State 10b. County ir then "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 √ Yes 2 No Baltimore MD Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21218 USA 3403 Harford Road by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 20 No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black White etc. within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify: Specify: white 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygiens Important: If Item 27 is marked other that eny injury or other traumatic event, 126, 0008. own home homemaker 18 Mother's Name (First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John Stanton Marjorie Helena Grace မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3403 Harford Road Baltimore, MD 21218 Vera Patterson/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State '4 □Donation 5 ♥ Other (Specify) in state 21. Signature of Euneral Service Licensee de Barector 3 tare and Affat of Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part. Enter the diseale, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition DEHYDRATION Physician resulting in death) /Medical Due to (or as a consequence of): Examiner POOR ORAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the death certificate be executed DEMENTIA that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of): attending physician Completed by Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Year Month Day in the past 12 months? detached for 5 Other (specify) ☐Yes 2 No the 9 Unknown ģ The faw requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. should be 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? page 2 s has 1 ☐ Yes Physician: director, 25. Was case referred to medical examiner?
1 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Vursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 1 Matural Injury or Attanding 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident in by the within 24 hours after deatl To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide pelli To the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29a. Certifies 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 20060560 pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person. BAYLRIVER NECK LVAK 201 PANKAJ KHE 32. Registrar's Signature, 31. Date filed (Month, Day, Year) State 7 2003 Registra

Baltimore, Maryland 21215-0036

P.O. Box 68760,

of Vital Records,

Division

State of Maryland / Department of Health and Mental Hygiene 0 05 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Jeanette G. Fedd 28,2005 7:17P. Oct. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 20th Street Apt.3Q Baltimore W. If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 ☐ M 2 🖫 F 14,1932 Maruland Director 218-28-6755 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturat", or itema 23a or 28a-f ahow the Medical Examinar must be notified at 1√2 Yes 2 No N/A Baltimore Directo Maryland t0e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Apt. 30 21218 USA 11 W. 20th Street Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specia LACK 1 ☐ Yes 2 ☐ NM Specify: þ If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ith and Mental Hygiene. 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) John Calvin Warren Alice Berryman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Heelth a Important: if item 27 is any injury or other traconce. Ray Fedd/ Son 2944 Greenmount Ave Baltimore, Maryland 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 11/3/051 □Burial 2 □ Cremation 3 □ Removal from State King Memorial Park Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Buneral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, Md 21215 22. Name and Address of Facility 23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Ollry Approximate Interval Between Onset and Death mmediate Cause (Final Priysician myveardial disease or condition resulting in death) /Medical Due to (or as a constituence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in dealh) Last Due to (or as a consequence of) attending physicien and for use as the burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed net enum Due to (or as a on equence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy performed certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 sesidence 6 Other (Specify) 1 ☐ Yes 2 V No ဥ this After this funeral d 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manney of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: / 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours e To the Funeral C Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the state of 29b. Signature and title of certifier 29c. License number 128541 Ledurner M 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maiden CUETO LEDUVINA 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2005 Registrar

			1 - State Amend Item#1 Registratemend Item	per PHY 6849 #10e&18 Per	PM1/09709 FH G849971	tment of F 1997/0 5	lealth and l D ga th	Mental Hyg	ien 2 0 0 5	35761
ø,	* Division		1. Decedent's Name (First, Middle, Las	t LENARD				2. Date of Deat Month	h Day Year	3. Time of Death
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	Funeral	111.0	5. Social Security Number 6. So	X M 2 F		If Under 1 Year Months Days	Hours Min.	(Month, Day,	Year) _ C	rthplace (State or Foreign country)
37	Director		225-42-9981 1. Usual Residence of Decedent		10			JAN.O	0,1735 Y	IRGINIA
	yland Now		10a. State 10b. County	100	c. City, Town or Loca	tion				10d. Inside City Limits
	r 28a-f show	to	MARY/AND K	1/A		BAL	TIMOR	E CIT	ry	1 X Yes 2 □ No
	with the Maryland a or 28a-f ahow Les notified at	Director	10e. Street and Number C1	areway		10f. Zip Code		1	0g. Citizen of What C	Country?
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	8 5	Funeral	11. Marital Status	12. Was Deceden Ever Armed Forces?	in U.S. 13. Wa	as Decedent of H es, specify Cuba	lispanic Origin? (Si an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh	
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land	Aenta Aenta rked tic ev	To B	JUDGE	/	FARRA	R	SALL			DERSON
a	and ha	•	19a. Informant's Name/Relationship (A		Address (Street	and Number or Ru	ral Route Number	City or Town, State,	Zip Code)
Σ.	and and selth		BARBARA BELL	. (NEICE		TOCKM	ILL RD	, APTC,	PIKESVILL	E MD: 21208
more,	of He		20a. Method of Disposition 1 Burial 2 Cremation 3	Dames of from State	 Place of Disposit cemetery, crema 	tory or other place			20c. Location - City o	•
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ă	permit. Departminimporte any inju		21. Signature of Funeral Service Licen	see III	22.1	Name and Addre	ss of Facility	ROWN	TR. FUNE	RAL HOME
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Вох	death certiff e attending id for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐		ctopic pregnancy	,		23d. Date of de	*
	0 0 0	lcla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time		Other (specify)			Month	Day Year
о. О	at the de by the a	hys	9 🗆 Unknown							
s,	res tha igned be det	by F	Part II. Other significant conditions o		t resulting in the und	erlying cause giv	ren in Part I.			to the cause of death?
ğ	w require been sign	ted	ATRIAL FIG	RILLATION				1 L Ye	s 2∐No 3≝F	robably 4 Unknown
ပို	as be	Completed	DIABETES					24a. Was a autops	y prior to	autopsy findings available completion of cause of
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ita	cien: ertific actor,	Be	25. Was case referred to medical examiner?					ath (Check only on	ө)	
5	Physi this c	P	1 ☐ Yes 2 ☑ No		2 ER/Outpatient		4 Linursing n		nce 6 Other (Sp	ecify)
Ĕ	ding P h. After funera	lon:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. Time of Injury	28c. Injur Wor		28d. Describe ho	w injury occurred	
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<u>></u>	or A after Direction by	ertif	4 Homicide determined	building, etc. (S		it, lactory, office		City or Town		nulai Hobie Wullber,
_	spitel ours nerel filled		29a. Certifier 1 Certifying Ph	ysicien: To the best of m	v knowledge, death o	occurred at the tir	me, date and place	and due to the ca	ause(s) and manner a	as stated.
	24 h	edical		niner: On the basis of exa and manner stated.						
	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the	Me	29b. Signature and title of certifier	A		29c. Licens	se number	00 2	9d. Date signed (Mor	nth, Day, Year)
	0		1 Aren	Cons		1)00	1521	67	11/11	05
1	di		30. Name and address of person with	completed cause of death	(Item 23a) (Type, Pr	rint)	3 0 1			
1	\		GIREGORY COPE	4740 E	ASTERN A	verve.	BALTIMO	RE, MA	PRYCAND	21224
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.K.S		Pleas	e Type or Print in Bl	ack Indelible Ink	. Ensure All Cop	ies Are Legible	
ILLIAM GATI	JIN						35763
		1 - Stata Unpend Item	State of Maryland 23a,pt.II,27,28	a—f _C per me G8	49 11–9–05 tas	Rag. No.	33103
		1. Decedent's Name (First, Middle,			2. Date	of Death	3. Time of Death
Physicia	_	Muliane	SATILING THE	•	NOV		8:50 P ^M
/Medic Examin	4.0	4a. Facility Name (If not institution SINAI HOSPITAL	give street and number)	4b. City, Town,		4c. County of De	0.00 1
	ě.	SINAL HOSPITAL		BALTIN	or Location of Death MORE CITY		
Funeral	- 1	5. Social Security Number 6	3. Sex 7. Age (In yrs. las		If Under 24 Hrs. 8. Date	of Birth 9. B	irthplace (State or Foreign Country)
Director		214-88-0866	10 M 20F 39	Yrs. Months Days	Hours Min. (Mon.		DARYLAND
9 g		Usual Residence of Decedent					
the Marylar 28a-f ehow	_	10a. State 10b. County		Town or Location			10d. Inside City Limits
Ba-f	cto	MD,	101	ALTIMORE			Ves 2□No
1215-0036 within 72 hours after death with the Maryland ane. ane. Than "natural" or items 23e or 28e-f ehow and the right and the righted at	Funeral Director	10e. Street and Number	4	10f. Zip Code		10g. Citizen of What (Country?
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ar de	nue	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? d 1 ☐ Yes 2 No	 Was Decedent of If Yes, specify Cut 	Hispanic Origin? (Specify Yes oan, Mexican, Puerto Rican, et	or No- 14. Race - Am c.) Black, Wh	nerican Indian, nite. etc.
36 safte	by Fi	1 Never Married 2 Marrie	II Yes, Give	1□Yes 2 No		Specify:	PIACK
5-0036	g p	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			1	
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2121 od within giene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	CONSTRU		PRIVATE	INDUSTRY
		17. Father's Name (First, Middle, La	1St)		18. Mother's Name (First, M		/
Maryland d 2 should be file th and Mental Hy Y7 is marked oth traumatic event	o Be	William Russe	ELL GATLING I	11		FITZHU6H	<i>!</i>
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ore, M		20a. Method of Disposition	20b. Plac	ce of Disposition (Name of	Date Date	20c. Location - City of	Town State
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Baltimol permit. Pages Department of important: If I any injury or o		4 □Donation 5 □ Other (Special Signature of Funeral Service Li	11/2/11	22. Name and Addre	Ry NOV. 8.20	05 BALTO,	MO.
Bal permi Impo		21. Signature of Julieral Service El	11-1	22. Name and Address	ass of Facility Hillip	4 WEATHER FOR	ed Fun. Sen. P. H
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		snock, or neart failure. List of	nty one cause on each line.	Do not enter the mode of dyl	ng, such as cardiac or respirat	ory arrest,	Approximate Interval Between Onset and Death
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/Medical Examiner		resulting in death)	Due to (or as a conseque	nce of):			
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ecuted and -transit	carr	that initiated events resulting in death) Last	C.	0			
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Box 68760, eath certificate be exe attending physician a for use as the burial.	Completed by Physician/Medical	· ·	d				
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e de the a	SIC	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of dea 9□ Unknown	th 5 ☐ Other (specify) _			Day Year
P.O. BOX that the death cer ed by the attendin detached for use	윤						
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w require	ted	nechadone and na	ICULIC USE			1 Yes 2 No 3 F	robably 4 Munknown
Division of Vital Records, or Attending Physicien: The law requires the affect death. Director: Affect this certificate has been signed in by the funeral director, page 2 should be death.	ble					Was an autopsy 24b. Were a	utopsy findings available completion of cause of
The The page	Ö					performed? death?	s 2 No
f Vital Recystician: The laving certificate has director, page 2	Be (25. Was case referred to medical examiner?			26. Place of Death (Check of	/\	
of V	2	1 X Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 XEF	NOutpatient 3□ DOA	ner: 4 Nursing Home 5	Residence 6 ☐Other (Sp.	ecify)
n on one rate of the rate of t	Ë	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury 29 Found Day Year)	8b. Time of unk 28c. Inju Injury Wo	ry at 28d. Desc	ribe how injugat occurred	unk
ath.	atle	2 Accident investiga	tion 11-2-05		Yes 2X No		
Visite of the control	Ħ	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	t be ed 28e. Place of Injury - At hom- building, etc. (Specify)	e, farm, street, factory, office	28f. Locat	ion (Street and Number of For Town, State) 3407 W	Rural Route Number,
D saft or saft of in ordinate ordinate ordina	Certification:		Found in hous		Parkwa	ay, Baltimore	. MD
hound Line	cal	29a. Certifier 1 Cartifying (Check only 27 Madical Ex	Physician: To the best of my knowle	edge, death occurred at the ti	me, date and place, and due to	the cause(s) and manner a	s stated.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exemple 24 to the Funeral Director: After this certificate has been signed by the attending physician a completely filled in by the funeral director, page 2 should be detached for use as the burial-	Medical	one) X	taminer: On the basis of examination and manner stated.			ume, date and place, and du	e to the cause(s)
To t	≥	29b. Signature and title of certifier	121	29c. Licens		29d. Date signed (Mon	th. Day, Year)
		Laval	Hallow n	9 0	.C.M.E	NOV. 3, 2	:005
		30. Name and address of person w	no completed cause of death (Item 2				
		CALELHA	ZLANNY 111	PENN STREET,	BALTIMORE, MAR	YLAND 21201	
Sta		31. Date filed (Month, Day, Year)	33 Registrar's Signatur	" hacks			
Registra	ar	NOV 0 7 2	005 Alexan A.	Marie			
		140	#				



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 630 November 2,2003 social W Gutovski /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore, Maryland Mercy Medical Center If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1₩ 2□F Yrs. Feb. 23,1941 64 Maryland Director 216-36-2049 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 No Baltimore City Maryland N/ADirect 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21224 United States 132 North Streeper Street death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 5 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Š 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) e filed within al Hygiene. I other then College (1-4or 5+) Elementary/Secondary (0-12) Shipping Industry Longshoreman 7 Years 18 Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumattic event 90se. Helen Yuchniewicz James Gutowski 19a. Informant's Name/Relationship (Type, Print) Sister In 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Law 0100 North Roundary Road Dundalls Maryslan Mrs. Geraldine M. Gutowski 8100 North Boundary Road Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Entombment oak Lawn Cemetery 11/7/2005 Baltimore, Maryland 22. Name and Address of Facility 7922 Wise Ave. Dundalk, MD 2122; 21. Societive of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. Epler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or-as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit be executed and Due to (or as a consequence of): Box 68760 Physician/Medical the as attending esn 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day o in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ned by the a P.0. 9 Unknown 9 Unknown ate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records. 1 Yes 2 No 3 Probably 4 Unknown leted 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Compl 2 No 1 TYes 1 ☐ Yes Division of Vital 25. Was case referred to medicat examiner? 26. Place of Death (Check only one Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death of or Attending Patter death. Certification: Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide To the Hospital within 24 hours a To the Funeral C completely filled: Hospital Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MO 15875 11/02/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore. 301 St. Paul Place MD 21202 32. Pagistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 15 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Rose A. Glorioso November 2005 12:15 A [™] /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Timonium Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🕇 F Months Days Year, Hours Min. 215-22-1024 83 Yrs. 1922 Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "naturel", or Iteme 23e or 28e-f show treumatic event. I'm Madical Examiner must be notified at 1 ☐ Yes 2 X No Director Md. Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Cameron Court Apt. F. death 21236 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed with Jealth and Mental Hygiene. IM 27 Is marked other then Factory Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Armetta Mary Constantino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 6 Cameron Court Mr. Michael F. Armetta/Brother other t Apt. F Baltimore, Maryland 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ō 1 Burial 2 □ Cremation 3 □ Removal from State ō Department of Importent: If eny injury or once. Dulaney Valley Mem. Grd. 11/7/05 Timonium, Maryland ⁴ □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensy 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia Weeks /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Physician/Medical Examiner that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760 physician the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yes 2.⊠ No 1 Yes 2 🖾 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 ☐ Yes 2 No 4⊠ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred Injury 1 X Natural death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of aximination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERNESTINE WRIGHT, 2300 DULANEY VALLEY ROAD M.D.TIMONIUM 21093 MD32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 7 2005 Registrar

3, 2005

NOVEMBER

GLORIOSO, ROSE

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** NOVEMBER 2005 5:47 Katherine Gary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 X F 06/03/1938 Director 67 Ireland 086-46-4023 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Md. Baltimore Ruxton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Roland Court 21204 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 5(+)Reg. Nurse health care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental ပ Patrick Meade Mary Mahoney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is nay injury or other traum 2 Roland Court Ruxton, Md 21204 Dr. Nader GarGarv 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 11/05/05 Hilltop Ser. Corp. Towson Md. 21204 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 York Road Towson, Md 21204 Ruck Towson Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** acere /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Dav 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 No the 9☐ Unknown 9 Unknown Š signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Yes 2 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ER/Outpatient 2 3 DOA 28a. Date of Injury (Month, Day Year) After thi funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death. 2 Accident within 24 hours after deat To the Funeral Diractor: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🖺 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 601 gistrar's Signatura 31. Date filed (Month, Day, Year) Registrar

State of Maryland / Department of Health and Mental Hygiene [] 5 For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** 3, 4:56 P Gretz November 2005 Francis /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Dundalk 7009 Mornington Road If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 30, 1918 7. Age (In yrs. last birthday) If Under 1 Year Months Days Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours 1**∑**M 2□F 87 Yrs 214-01-3883 PA. Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State show "natural", or items 23a or 28a-f show 1 ☐ Yes 2 X No Director MD Baltimore Dundalk 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 7009 Mornington Road 21222 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, It a Medical Examinate must 2008. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 3 Widowed 4 □Divorced þ Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self-Emloyed Restaurant 12 years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John E. Gretz Mary Harper 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Daughter 226 N King Street, Leesburg, VA 20176 Anita Gallagher 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition November 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 7, 2005 Dundalk, MD. 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Part 1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. It is only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CA pancreas, metastatic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to mind substicause. Enter Underlying Cause (Disease or injury that initiated events Dise to for as a gonsectioned off-Examiner The law requires that the death certificate be executed ettending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
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within 24 hours after death.
To the Funeral Director: Aftr 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 riflying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #200, Lutheville, MD 10755 Falls Road, 21093 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

			For	State of Ma		rtment of Health a		ntal Hy	giene	005	35768
			1 - Stete Registrar		Cen	tificate of Death			Reg. No.		
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	/Medic	al	4a. Facility Name (If not institution, o	MADOOX	91011	4b. City, Town, or Location of	of Death	11	40.0	County of Deatl	11.00 P N
	Examin	er	Boltzines Dollal	Petetian I	Standad Car	e Bolton	ore				
	Funeral		5. Social Security Number 6		(In yrs. last birthday)	If Under 1 Year If Under Months Days Hours		Date of Bir	rth	9. Birth	place (State or Foreign
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	n 72 hours after death with the Maryland "netural", or Items 23a or 28a-1 show edical Evaninat must be notified at	tor	MD Pril-	imore.	Owings	· Mills					1 ☐ Yes 2 No
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	tems	nner	11. Marital Status	12. Was Decedent I Armed Forces?	lf.	as Decedent of Hispanic Ori Yes, specify Cuban, Mexican	gin? (Specin	fy Yes or No can, etc.)	0- 1	4. Race - Amer Black, White	
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Ď	Department Department		> Vaughn !	. Steene	8	128 Liberty R	W. R	andw	Uston	A	4 11 77 77
			23a. Part1. Enter e disease, or co shock, or heart failure. List or	omplications that caused by one cause on each lin	the death. Do not ente	r the mode of dying, such as				,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Conge	stille lie	est failur	0				Onset and Death
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00		Medi	IF FEMALE:								
X O O	leath certific attending pl	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth		Ectopic pregnancy			23	3d. Date of deliment	very Day Year
	the all	Physician/M	1 Yes 2 No	4□Pregnant at 9□ Unknown	time of death 5	Other (specify)				WOTE	Day Feat
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VII		a	25. Was case referred to medical			26. Place	of Death (1 Yes	2 No	1 🗆 Yes	2 U No
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ō	Attending Physic death. ector: After this by the funeral di		27. Manner of Death 1 KNatural 5 □ Pending	28a. Date of Injui (Month, Day		28c. Injury at Work?		d. Describe			
IVISION	Attendir death. ctor: Al y the fu	catle	2 Accident investigation			M 1 Tes 2 1	No	_			
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_1	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier ™ Certifying	Physician: To the host	of my knowledge, death	onguing at the time date and	4-1	d d	(-)		
	24 hc 24 hc Fun etely l	edical	(Check only 2 Medicel Ex	aminer: On the basis of and manner sta	examination and/or inve	occurred at the time, date an estigation, in my opinion, deal	th occurred	at the time,	date and p	and manner as place, and due	stated. to the cause(s)
	within To the compl	Me	29b. Signature and title of certifier			29c. License number			29d. Date	signed (Month	Day, Year)
	/		Algertin C	here md)	D-182	G8		11	lilat	-
1			30. Name and appress of person wh	no completed cause of d	eath (Item 23a) (Type, P	rint)	10		• //	1103	
V			AUGUSTIN CHYU.	MD. 3900	LochRa	on Blud.	Ball	imo	e.	4D 2	2/2/8
	Sta		30. Name and address of person when the stress of person when the stre	32. Registra	r's Signature		00				
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05 Certificate of Death Reg. No. 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** November 3, 2005 11:05 P.M. Adelaide Gardner /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Genesis Eldercare - Severna Park 24 Truckhouse Rd. Severna Park Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Months 1 □ M 2 1 F Yrs. March 8, 1912 93 Director 214 82 6433 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any Injury or other treumatic event, I'm Medical Exercited Inset be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director Glen_Burnie Maryland | Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21061 United States 725 Delaware Ave. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: white þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) æ Anna Menton ဨ James Kellv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Burnie, MD 21061 Sharon Borkmann / Daughter 400 Delmar Ave. 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov. 7, 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Memorial Park 2005 Glen Burnie, MD 21. Signatura of Furural Sovice Licensee 22. Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy. S.E. Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** PNEUMONIA 3-4 DAYS Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner ate hes been signed by the attending physician end page 2 should be deteched for use as the burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of. Division of Vital Records, P.O. Box 68760 Physiclan/Medical Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☐ No this certificate To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 2 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 ANatural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steled.

| Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and Rie of certifier wallace mos C. WACLACE, MM, 9005 KICBRIDE RD, BALTIMORE, MD 21236

th, Day, Year) 32 Degistrar's Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

NOV 0 7 2005

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	Funeral	5	Social Security Number 6.	Sex 7. Age (III 1⊠ M 2□ F	n yrs. last birthday)	If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year, 1019 2, 196	9. Birt	hplace (State or Foreign cuntry) cyland
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	and	-	Usual Residence of Decedant 10a. State 10b. County	10	Dc. City, Town or Lo	cation				10d. Inside City Limits
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	within 72 hours after death with the Maryland ene. Ithan "natural", or items 23e or 28e-f show the Medical Examiner must be notitied at	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13. V	Vas Decedent of H f Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No- Rican, etc.)	 Race - Ame Black, Whit 	
ထ္က	or Ite	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 🔀 No If Yes, Give	,	1 ☐ Yes 2 ☑ No	Specify:		Specify: 15	1 0012
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	s 1 and 2 should f Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship Shaneka Green/I	(Type, Print))aughter	19b. Mailir 25	ng Address <i>(Street</i> 71 W.Fave	and Number or Rura ette ST. B	Route Number, City altimore, M	or Town, State, 2 D. 21223	Zip Code)
∑,	1 and 2 Health tem 27	- 9			20b. Place of Dispo				_ocation - City or	
0	ges 1 ar it of Hea if item or othe		20a, Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	□Removal from State	cemetery, crer	natory or other pla Carmel Ce	^{сө)} em. 11/11		Balto.MD	
ij	it. Pa rtmer rtent njury	1	*4 Donation 5 Other (Spec		22	2. Name and Addre	ess of FacilitY a 1 v	ip₅Willian	ns FIIN.	SER.
Ba	permit. Pages 1 Department of H Importent: If ite any Injury or ot once.		21. Signature of "gneral Serve Lic Ronal 11	Wade , Dive			MD 21261			11651
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of	Phys r this ral dii	T.	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time of			28d. Describe how in		ouny)
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Division	Atter rr dea ector by the	HCa	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	t be 28e. Place of Injur- building, etc.	y - At home, farm, st	reet, factory, office		28f. Location (Street City or Town, Sta		Rural Route Number,
ā	s afte	Certification;					1			
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	ical	(Check only 2 Medical E	Physician: To the best of caminer: On the basis of c	examination and/or i	th occurred at the t nvestigation, in my	time, date and place, opinion, death occur	and due to the cause red at the time, date a	(s) and manner a ind place, and du	as stated. ue to the cause(s)
	the hin 24 the F	Medical	one) 29b. Signature and title of certifier	and manner state	ed.		nse number		Date signed (Mor	
	To vite		250. Signature and title of certifier	125 1		11				2
7			30. Name and address of person w	no completed dayse of do	ath (Item 23a) (Type	Print)	70/14	00	1 Heart	hery lad
	(12)		50. Name and address of person w			/ -	earl 1	Candarlis/	EWR	le ar lad
	S	ate	31. Date filed (Month, Day, Year)	32. Registrat	's Signature	12 m				-1
	Regist		NOV 0 7 200	5 Landon o	No. John					

			1 - For State Registrar	State of Ma	ryland / Depa <i>Cer</i>	artment of Hertificate of D	ealth and Me Death	ental Hygier		35771
ı	Physici /Medic		Decedent's Name (First, Middle, Las COY		OISON			2. Date of Death Month NOV . 2	Day Year 2005	3. Time of Death 8:19AM
	Examin		4a. Facility Name (If not institution, give 2404 ASHLAND AT 5. Social Security Number 6. Se	ZENUE	(In yrs. last birthday)	4b. City, Town, or I) D F		4c. County of Dea	
	Funeral Director			¬ м 2 □ E	6 Yrs.	Months Days	Hours Min.	(Month, Day, Yes		AROLINA
	Maryland -f ahow iled at	tor	10a. State 10b. County MD • N/A		10c. City, Town or Lo	cation TIMORE				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the	i Direc	10e. Street and Number 2404 ASHLAND A	VENUE		10f. Zip Code	.205	10g.	Citizen of What C	21
9	after death or items 23	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒️Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give		Vas Decedent of His f Yes, specify Cuban	panic Origin? (Spec , Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Am Black, Whi	te, etc.
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f ahow than "netical Eral" bar must be collified at	Completed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed (Specify only highest grad	Year or Dates: ucation de completed)	16a. Deced	dent's Usual Occupation of work done du DO NOT use retired)	ion	g 16b	Specif BLA Kind of Business	
	filed with Hygiene. other than	Be Com	Elementary/Secondary (0-12) 8 17. Father's Name (First, Middle, Last)	College (1-4or 5-	LAB	ORER	18. Mother's Name		ALTIMOR	E CITY
Maryland	hould be id Mental markad (matic ev	ToB	SHEPPARD GRAD 19a. Informant's Name/Relationship (7		19b. Mailin	ng Address (Street ar		DURANT	v or Town State	Zin Code)
altimore, Ma	pernit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Items 23a or 28a-f ahow any injury or other traumatic event, the Medical Exaction front be notified at another.		LILLIAN GRADISC 20a. Method of Disposition 1 Burial 2 Cremation 3	N (WIFE)	2404 20b. Place of Dispo cemetery, crem	ASHLAND sition (Name of natory or other place	AVENUE	BALTIN te 20c.	MORE, MD	. 21205
Baltin	permit. Pa Departme Important any njury		2 Sponation 5 □ Other (Specify 2 Structure of Funeral Service Licen	7/Ser		Name and Address CALVIN B 412 E. P	of Facility SCRUGO RESTON		RAL HOM BALTO,	E MD. 21213
8760,	/Medical Examiner bhysician and the burial-transit	dicai Examiner	23a. Part1. Enter the disease, or compshock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. A 2 T 5 2 Due to (or as a c.	the death. Do not entered to some of the consequence of): Consequence of): Consequence of):	C CARSI			ZE	Approximate Interval Between Onset and Death () YEAZ (
P.O. Box 68	death certifi e attending ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 24 □ Pregnant at 19 □ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
rds, P.	law requires that the deas been signed by the a	ρλ	Part II. Other significant conditions of						h-m	o the cause of death?
Il Records,	The ate h page	Completed	EMPNYSEMA					24a. Was an autopsy performed 1 Yes 22	prior to death?	utopsy findings available completion of cause of
Division of Vital	nding Physician: Th tth. :: After this certificate e funeral director, pag	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injur (Month, Day	nt 2 ER/Outpatier y 28b. Time of Injury	of 3 DOA Other	26. Place of Death of 4 Nursing Hom at 28		6	icity)
Divisi	or Attanding after death. I Director: After d in by the fune	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At home, farm, str . (Specify)	eet, factory, office	28	Bf. Location (Street City or Town, St		ural Route Number,
	To the Hospital or Attanowithin 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Ph (Chack only 2 Medical Examone)	ysician: To the best on niner: On the basis of and manner state	examination and/or in	n occurred at the time vestigation, in my opi	e, date and place, ar nion, death occurred	nd due to the cause d at the time, date a	o(s) and manner a and place, and du	s stated. e to the cause(s)
	within 2. To the I	Me	29b. Signature and title of certifier Nathan A Sc	att m m	· v) .	29c. License	number 3 4 4 8 4	29d. I	Date signed (Mont	
h			30. Name and address of person who of MATMAN A - SCOTE	completed cause of de	eath (Item 23a) (Type,	Print)	200 150 250	DEF MA	13 - 5	21202
3	Sta Regist		31. Date filed (Month, Day, Year)	3 Registra	1000 £ ,	WE .	D NOTTH		1, 3/	21102

		1 - State Amend Item Registrar 1. Decedent's Name (First, Midd)		849 11,	Toca	tificate of l	Death			No.	J (70112
Physic /Med		20NA 40	e, Last/		HA	RRIS		Mont Nont	of Death h	Day Zo	Year	3. Time of Death 22 46 M
Exami			1aryland Me	dia(Ce		4b. City, Town, or Bultin	OR			4c. County o	N/A	
Funeral Director		5. Social Security Number 220-64-8155 Usual Residence of Decedent	6. Sex 7.	Age (In yrs. Ia 51	st birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min. (Mon.	of Birth th, Day, Ye 05/19			ace (State or Foreigr try) YLAND
ryland how		10a. State 10b. County		10c. City,	Town or Lo	cation					10	Od. Inside City Limits
he Ma 28a-f s	Director	MD	N/A			BALTIMO	DRE C	CITY	-			XXYes 2□No
with 1	Dir	10e. Street and Number 1014 POPLAI	CROVE ST	ਾਕਬਰਾ		10f. Zip Code	2121	6		Citizen of Wi	nat Coun	try?
death ms 23	Funeral	11. Marital Status	12. Was Decede	nt Ever in U.S	. 13.	Was Decedent of Hi f Yes, specify Cuba				JSA 14. Race		
be filed within 72 hours after death with the Maryland nia! Hyglene. Id other than "natural", or items 23a or 28a-f show event, the Madical Examiner must be natified at	b	1 □ Never Married 2 💢 Mai 3 □ Widowed 4 □ Divorcei	If Yes Give	XV₀		f Yes, specify Cuba 1 □ Yes 2 X No	Specify:	i, Puerto Rican, <i>e</i> t	c.)		, White, e	
72 ho 'natur	eted		nt's Education est grade completed)		(Give	dent's Usual Occupa	durina mos	t of working	16b	. Kind of Bus	iness/Inc	lustry
within ene. than "	Completed	Elementary/Secondary (0-12) 12TH	College (1-4	or 5+)		DO NOT use retired RUCK DRI	•		п	ז א א סי	о∩ът	ATION
filed Hygid other	0	17. Father's Name (First, Middle,	Last)			CON BIG		or's Name (First, N				ATTON
should be filed within and Mental Hygiene. s marked other than umatic event, the M.	To B	JAMES HARF	RIS				JA	NIE FI	TZGE	RALD		
a a a a		19a. Informant's Name/Relation. VIVIAN HARF				ng Address (Street a				•		•
f Health tem 27 other tr		20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·		ce of Dispo	sition (Name of		Date	-	Location - C		
Pages nent of int: If it		1 ▼Burial 2 □ Cremation 1 □ Donation 5 □ Other (IIA	-	natory or other plac EMORIAL		11/08/0	5 R	ANDAI	LST	OWN, MD
perril. Pages 1 and Depurtment of Health Important: If tem 27 any njury or other tronce.		21. Signature of Toneral Service	Licensee	Der		Name and Addres			FUN	ERAL	HOM	
		23a. PAV1. Enter the discase, o	r complications that caust only one cause on each	sed the death.						_,,_		Approximate Interval Between
Pnysician		Immediate use (Final dise e condition result in death)		Itrace	. /	(14.9)		hage			6	Onset and Death
/Medical Examiner		result in death)	Due to (or	as a conseque	ence of):	- 11		0				7-
	e.	Sequentially list conditions,	b. Due to (o	a conseque	ence of):	2					1	Kan
xecuted and il-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C									
be e ician buria		resulting in death) Last	Due to (or	as a conseque	ence of):							
ificate g phys as the	edicai		d									
leath certific attending p	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	me of pregnand		Ectopic pregnancy				23d. Date		•
requires that the death certific een signed by the attending p nould be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		t at time of dea		Other (specify)			_	Mont	n	Day Year
res that t signed by I be detail	by Ph	Part II. Other significant conditi	ions contributing to deat	h but not result	ing in the u	nderlying cause give	en in Part I.	23e.	Did tobacc	o use contrib	oute to the	e cause of death?
w requires been sig should be								_	1 🗌 Yes	2 □ No 3	Proba	ably 4 © Unknown
law as b	ompleted								Was an autopsy performed	pri ? de	ere autopior to comeath?	sy findings available
i cien: T h certificate rector, pag	Be C	25. Was case referred to medica examiner?	ał .				26. Place	of Death (Check		10		
등 등 등	2	1 🗆 Yes 💸 No	Hospital: 1 Imp		R/Outpatier			rsing Home 5)
S S 19	11 22 1	27. Manner of Death 1 ■Natural 5 □ Pendi	28a. Date of I (Month, igation	Day Year)	8b. Time of Injury	Work			cribe how in	jury occurre	d	
	tior	2 Accident Invest 3 Suicide 6 Could	not be 28e. Place of	Injury - At hom etc. (Specify)	e, farm, str	eet, factory, office		28f. Loca	tion (Street or Town, St		or Rural	Route Number,
	rtification	4 Homicide determ	building,									
	cal Certification:	4 Homicide deterr 29a. Certifier Certifyi	building,	est of my know	ledge, deatl	occurred at the tim	ne, date an	d place, and due to	time date	(s) and man	ner as sta	ited.
• Hospitel or Attending Ph 24 hours after death. • Funerel Director: After th stely filled in by the funeral	edical	4 Homicide determined to the state of the st	building,	est of my know s of examination stated.	ledge, death on and/or in	occurred at the time vestigation, in my op	ne, date and pinion, deal	d place, and due t th occurred at the	time, date	(s) and mana and place, an	ner as stand due to	ited. the cause(s)
ding Ph J. After th funeral		4 Homicide 4 Homicide 29a. Certifier (Check only 2 Medical	building,	est of my know s of examination stated.	ledge, death	occurred at the time vestigation, in my operations are seen as the company of the	ne, date and pinion, deal	d place, and due to th occurred at the	o the cause time, date a	o(s) and maniand place, an	ner as stand due to	ated. the cause(s)
• Hospitel or Attending Ph 24 hours after death. • Funerel Director: After th stely filled in by the funeral	edical	4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certify	building,	est of my know s of examination stated.	ledge, death on and/or in: UD.	29c. License	ne, date and pinion, deal	d place, and due to th occurred at the	29d. I	o(s) and maniand place, and place, and place, and place signed (ner as stand due to (Month, E	ated. the cause(s) Day, Year)
Hospitel or Attending Ph 24 hours after death. Funerel Director: After th stely filled in by the funeral	edical	4 Homicide determined to the state of the st	building,	est of my knows of examination stated.	ledge, death on and/or in: M.D. 23a) (Type,	29c. License	ne, date ani- pinion, deal a number \$1.8	d place, and due to the occurred at the	29d. I	o(s) and mana and place, and Date signed (ner as stand due to (Month, E	ated. the cause(s)

,0,			For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of H	lealth and Death		eme 0 0 5	35773
	Physici		1. Decedent's Name (First, Middle, Last Pertina)	Hatche	er		2. Date of Death Month November	2°, 2005 ear	3. Time of Death 8:48 A M
	/Medic Examin		4a. Facility Name (If not institution, give 3601 10th Street	street and number)		4b. City, Town, or Baltin		th	4c. County of Dea	th
	Funeral Director		220-86-2835	7. Age	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	II Under 24 Hrs Hours Min		rear) Co	thplace (State or Foreign buntry) Md.
	Maryland -f show Lied at	tor	Usual Residence of Decedent 10a. State 10b. County Md - NA	1	10c. City, Town or Lo	cation				10d. Inside City Limits Yes 2 □ No
	with the a or 28s	Director	10e. Street and Number		Dair	10f. Zip Code		10	g. Citizen of What Co	ountry?
36	72 hours after deeth with the Maryland "neturet", or Items 23e or 28e-f show cilcal Exemination must be notified at	by Funeral	3601 10th Street 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give X	0	21225 Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2☐ No	ispanic Origin? (14. Race - Ame Black, Whit	
21215-0036	l within 72 hour iene. r than "natural ir e Medical Ex	Completed b	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		16a. Dece (Give	dent's Usual Occup s kind of work done of DO NOT use retired	during most of wo		6b. Kind of Business	
land 21	be filed ital Hyg id othe event,	To Be Cor	10th grade 17. Father's Name (First, Middle, Last) Johnnie	L.	Une Hatch	employed	18. Mother's Na	me (First, Middle, Mi		Davis
Maryland	12 should hand 7 is m	-	19a. Informant's Name/Relationship (T) Alice Harrison		19b. Maili	ng Address (Street	and Number or F	tural Route Number,	City or Town, State, .	
Baltimore,	Pages 1 and 2 nent of Health int: If item 27 ity or other tri		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ 1 4 □ Donation 5 □ Other (Specify,		20b. Place of Dispe	osition (Name of matory or other place	(e)	Date 2	Oc. Location - City or Dundalk,	
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens		2	2. Name and Address Narch F.H.		Baltimor	e, Md. 2 North Av	1202
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each lin	the death. Do not ene.					Approximate Interval Between Onset and Death
*	/Medical Examiner		resulting in death) Sequentially list conditions,	b						
8760,	cate be executed physicien and the burial-transit	ai Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	consequence of):					
9	rtificate ng physi as the	Medical	IF FEMALE:	d						
.O. Box	The law requires that the death certific the has been signed by the attending p bage 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 1 9 Unknown	2 ☐ Fetel death 3[□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	livery Day Year
s, P	w requires that i been signed by should be deta	by	Part II. Other significant conditions co	ntributing to death bu	t not resulting in the u	ınderlying cause gıv	en in Part I.	23e. Did toba	¥	o the cause of death? robably 4 Unknown
of Vital Record		Completed						24a. Was an autopsy perform 1 X Yes 2	prior to	utopsy findings available completion of cause of
f Vita	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 X Yes 2 No	Hospital: 1 ☐ Inpatier	nt 2 ER/Outpatie	nt 3□ DOA Oth		ath <i>(Check only o</i> ne) Home 5 🗆 Residen		on⁄y)at scene
	De 100		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	Year) Injury	Wor		28d. Describe how		1
Division	Atten r deat ector: by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc	ry - At home, larm, st (Specify)	reet, factory, office	700 2/2,10	28f. Location (Stree City or Town,	pet and Number or Ri State) 3601 10	um I Route Number
	To the Hospital or within 24 hours afte To the Funeral Directions of completely filled in I	Medical (rsicien: To the best of iner: On the basis of and manner star	examination and/or in			e, and due to the cau	ise(s) and manner as	
	To th withir To th comp	Me	29b. Signature and title of certifier	A D O CO	und	29c. Licens	e number .C.M.E.		d. Date signed (Mont ovember 3,	
X			30. Name and address of person who c	ompleted cause of de	1		treet. B	altimore,	Marvland	21201
	Sta Regist		31. Date liled (Month, Day, Year) NOV 0 7	32. Registra	r's Signature					

State of Maryland / Department of Health and Mental Hygien $oldsymbol{9}$ $oldsymbol{0}$ $oldsymbol{0}$ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Z Month **Physician** Year 0329pm November 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BACTIMORE UNIVERSITE HOSPI +AL pecialite If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months) Days Hours Min. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 2 M 2 □ F Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23a or 28a-f show treumetic event, the Medical Examiner must be notified at 1. Tes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Eve Armed Forces? in U.S 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□ Yes 2⊡ No Specify: Specify: 9 þ 3 ☐ Widowed 4 ☑ Divorced natural Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene Importent: If item 27 is marked other then "na any injury or other treumetic event, the Wedle once. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 19a. Informant's Name/Relationship)(Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Other (Specify) neral Service License 22. Name and Address of Facility 21. Signature of 23a. Part Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or lear failure. List only one cause on each line.

Immediate Cruse (Final disease or condition resulting in death)

a.

Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** 421 /Medical Due to (or as a consequence of): Examiner 401 eleusin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760. attending physicien Medical Certification; To Be Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death signed by the atter in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy 2 XNO certificate 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident filled in by the Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funerel Direct 29a. Certifier 🗺 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier alle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 691, South , MD MEHTA 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State 7 2005 NOV 0 Registrar

Amend item#8, perFh, 8849, 11-14-05 TT Department of Health and Mental Hygie per 15 35775 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Joyce E. Hilliard November 2005 5:00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Morningside House Ellicott City Howard 8. Date of Birth//20/1941 Birthplace (State or Foreign (Month, Day, Year) Country)
July 11, 1941 Pennsylvania If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 ☐ M 2 🖫 F 64 Vrs 184-32-3971 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 1 ☐ Yes 2 No Director MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5830 Dorsey Hall Road 21042 USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2**X N**o If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kenneth Snyder Ethel Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11325 San Andrew Drive, New Market, MD 21774 Dorinda Pastorek/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3X Removal from State North Freedom Cem. North Freedom, PA Nov 7, 05 ¹ 4 □ Donation 5 □ Other (Specify) Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00160 313 Talbott Avenue, Laurel, MD Muse Vandaion Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Advanced Dementia Physician /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physiclan/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Assisted examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 XOther (Specify) Living 1 ☐ Yes 2X No 2 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 1 🚰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

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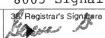
other traumetic event, the Medical Examiner must be notified at

Registrar

31. Date filed (Month, Day, Year) 7 2005 0

29b. Signature and title of certifier

Suzan Abdo, MD



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D50870

29d. Date signed (Month, Day, Year)

November 3, 2005

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 5.471M Johnson **Physician** November 2005 E 1,2abeth /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Howard County General Hospital Columbia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6/2/1924 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1 ☐ M 2 😿 F Hours Virginia 22 0602 81 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28e-f ehow Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene.

and it if team 22 le marked other than "ratural", or itema 23a or 28e-1 ehov and it is to other traumatic event, its Marylosi Examinat must be notified at any or other traumatic event, its Marylosi Examinat must be notified at 1 ☐ Yes 2 No Directo MDHoward Columbia 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 7080 Cradlerock Way #214 21045 U.S.A. 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed by White 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home maker Own Home 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Tucker Smith Louise Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 249 Glen Ct. Pasadena, MD Bruce Leatherwood/son 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If eny Injury or Bayview Crematory 11/4/2005 Baltimore, MD 22. Name and Address of Facility G. J. Gonce Funeral Home, 21. Signature of Funeral Service Licensee 169 Riviera Dr. Pasadena, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Endovasculas Diplone Examiner Attreso & Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed ettending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4⊡Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 3 Probably 4 Miknown 1 ☐ Yes 2 ☐ No Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No the Hospitel or Attending Physicien: 26. Place of Death Check only one funeral director. 25. Was case referred to medical examiner 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 Natural 5 Pending 1 Yes 2 No 2 Accident investigation within 24 hours efter death To the Funeral Director: filled in by the 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1) 30641 au 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) River Neck Food 201-109 Sabalalhi agmech Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month,

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	Examin		4a. Facility Name (If not institution, give JOHNS HOPKINS BAY		CENTER			Location of Deat	h		County of D	eath	
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Maryland	id 2 shou ith and M 27 is mar treumat		19a. Informant's Name/Relationship (7 Thelma Kalb (Wif					and Number or R					Code) 222
Baltimore,	ages 1 ar int of Hea t: If Item 2		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	Place of Dispo	matory or	other plac	1	Date	20c. Lo	cation - City		
Baltir	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked eny injury or other treumstic evonce.		21. Signature of Funeral Service Licen			Name a	and Address	ss of Facility k Funera se Ave.	1 Home	of Du	ındalk	, I	ryland nc. 21222
İ	Physician		23a. Part 1. Enter the disease, or composition shock, or heart fail re. List only of Immediate Cause (Final disease or condition	olications that caused the decone cause on each line.		er the mo	de of dyin		c or respiratory	arrest,	r y rain		Approximate Interval Between Onset and Death
900	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):	(400	ne C	MICHOUND [CA	אנינו אמא	CA SE			
, 0,	cate be executed physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										-
68760,		Aedicai	IS SECULIE	d							,		
P.O. Box	Physicien: The law requires that the death certific this certificate has been signed by the attending trail director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 5 □ Other (specify) 9 □ Unknown							23d. Date of delivery Month Day Yea			
	w requires that been signed b should be deta	ρ	Part II. Other significant conditions of	ontributing to death but not re	esulting in the u	nderlying	cause giv	en in Part I.			use contribut	-	e cause of death?
Division of Vital Records,	: The law re cate has bee : page 2 sho	Completed								opsy formed?		to com	sy findings available apletion of cause of
Vita	ysicien: Th is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 □ No	Hospitaf: 1 ☐ Inpatient 2	XER/Outpatier	nt 3[][Oth	or	ath (Check only		6 DOther /	Spacific	1
ion of	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral (27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injun Worl		28d. Describe			Specify	,
Divis	tel or Atters after de el Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)	reet, facto	ry, office			on (Street and Number or Rural Route Number, Town, State)			
	To the Hospitel within 24 hours of To the Funerel completely filled	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kininer: On the basis of examinand manner stated.	nowledge, death nation and/or in	h occurre vestigatio	d at the tin	ne, date and plac pinion, death occ	e, and due to the urred at the time	e cause(s) e, date and	and manne place, and	r as sta due to	ated. the cause(s)
1	To th Withir To th	Me	29b. Signature and title of certifier	1/1/	/	2	9c. Licens	e number			te signed (M		
6	HN		30. Name and address of person who	11	em 23a) (Type, 1 PENN	Print) STRE		BALTIMOR	E, MARYL				
7	Sta Registr		31. Date filed (Month, Day, Year)	2005 32. Redistrar's Sig									

State of Maryland / Department of Health and Mental Hygiepe 05 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** KOZHINSKAYA 2005 MOVEMBER 11 47 AM LORA /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** RANDALLITOWN BALTIMORE NORTHWEST HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Days Hours Min. (Month, Day, 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 ☐ F UKRAINE Yrs. Director 214-33-1141 82 06/02/1923 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthen "naturel", or items 23s or 28s-f ehow the Madical Executor coust be notified at 1. Yes 2 □ No Director N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3601 FORDS LANE 21215 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No WHITE þ 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) VIOLINIST MUSTC permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If item 27 is marked other any light of other treumatic event some. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SHESTOPAL AARON ROSA 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3805 PORTMAN PLACE-ELLICOTT CITY, MD 21042 OLGA ROSENTHAL / GRANDDAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) BALTIMORE HEBREW CONG 11/04/2005 REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 1000 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): days aurens /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of ettending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑No 24a. Was an certificate has 1 ☐ Yes 2 No Be (funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 2 1 ☐ Yes 2 反No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After or Attending 1 Natural 2 Accident 5 Pending 1 TYes 2 No within 24 hours after death. To the Funerel Director: A investigation the 6 Could not be determined 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) filled in by 4 Homicide 29a Certifier 🔀 Certifying Physician: To the best ol my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Durton D0059736 november 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL DEBORAL WATSON NO P-THINEST MD 5401 OLD COURT 31. Date filed (Month, Day, Year) 32. Signature State NOV 0

DHMH 17 Rev 1/2001

Registrar

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,			1 - State Unpend Item 23	State of Marylar a&27 per me	id / Depa G850-1	artmer 2-13- tifica	nt of H 05 ft	ealth a Bath	ind Me	ental Hy	giene Rag. No.	005	3	5780	ĺ
Xe	Physici		1. Decedent's Name (First, Middle, Last) ENGER LEE							2. Date of Dea Month Octobe:	ath Day	Year 200		Time of Death	_
-€ -€	/Medic Examin		4a. Facility Name (If not institution, give stre Maryland General Ho				Town, or	Location of		octobe.	4c. County of Death				
	Funeral Director		5. Social Security Number 6. Sex 217-56-6728	7. Age (In yrs. 56	iast birthday) Yrs.		r 1 Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da 06/01	y, Year)	9. Birt Co	u <i>ntry)</i>	(State or Foreign	1
ne Maryland 8a-f ehow	e Maryland	Director	Usual Residence of Decedent	10c. Ci	ty, Town or Lo		ORE	CITY					1	nside City Limits	
	as or 2	Dire	10e. Street and Number 1311 HARLEM AVI	ENUE		10f. Zi	Code 2 1	217				en of What Co JSA	untry?		
30	72 hours after deeth with the Maryland "natural", or freme 23a or 28a-f ehow idical Examiner must be notified at	by Funeral I		. Was Decedent Ever in U Armed Forces? 1 _Yes_XXVo If Yes, Give Year or Dates:			dent of Hi		jin? (Spec , Puerto R	ify Yes or No ican, etc.)	- 1	4. Race - Ame Black, White			
က်	within 72 hour ene. than "natural be Madical Ex	Completed b	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	tion	life. I	kind of wi DO NOT L	ork done d ise retired,	lurina most	of working	g	16b. Kin	6b. Kind of Business/Industry			Ĩ
and 21	be filed tal Hygi d other event, I	To Be Con	11TH 17. Father's Name (First, Middle, Last) ROBERT LEE PACE		נט	ISAB	PED	18. Mother		(First, Middle,		DISA Sumame)	BLE	ED	
ž ž	s 1 and 2 should if Health and Men itam 27 is marke other treumatic	ī	19a. Informant's Name/Relationship (Type CHARLES H. LEE / 20a. Method of Disposition	Print) HUSBAND		-		und Number	r or Aurai	Route Numbe	er, City or	Town, State, 2			
altimore,	nit. Pages vartment of I ortant: if its injury or of		1 ☐ Burial ② Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	emetery, crer ETRO C	natory or	otner place	9) ;		4/05		ONSVI			
Balti	Departition of the policy of t		21. Signature of Typeral Service Licensee 22. Name and Address of Facility HOWELL 4600 LIBERTY HEIGHTS									RAL H	OME	21207	
× 2	Physician /Medical Examiner	Examiner	Interval Betwee Conserval Actives on each line. Immunity and the condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last List only one cause on each line. Hemorrha is Pericardial Effusion Complicating Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										roximate rval Between set and Death VE		
O. BOX 687	death certificate e attending phys od for use as the	Physician/Medical	d IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o 9 ☐ Unknown	aldeath 3□	Ectopic p					23	8d. Date of deli Month	very Day	Year	
٦.	iaw requires that the de es been signed by the a 2 should be detached f	ρ	Part II. Other significant conditions contri	buting to death but not res	sulting in the u	nderlying	cause give	n in Part I.			obacco us Yes 2	e contribute to			
Vital Records,	The ate h page	Completed								24a. Was autor perfo 1 X Yes		24b. Were au prior to death?	complet	indings available ion of cause of No	
≦ 	iysician: Th iis certificate director, pag	o Be	25. Was case referred to medical examiner? 1 XYes 2 No	spital: 1X Inpatient 2	ER/Outpatier	nt 3 🗆 D	OA Othe			Check on v o		□Other (Spec	cify)		
Division of	ding Pt h. After th funeral	Certification: T	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c. Injury Work	at :? ∕es 2 □ N	28	3d. Describe f					_
	Mospital or Atten 24 hours elter deat Funeral Directors letely filled in by the		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci		eet, facto	y, office		28	3f. Location (S City or Tox	(Street and Number or Rural Route Number, own, State)				
	To the Hospital or within 24 hours efter to the Funeral Dir completely filled in	edical	29a. Certifier (Check only one) 1 ☐ Certifying Physic 2 ► Medical Examine	r: On the best of my known: On the basis of examination and manner stated.	owledge, death ation and/or in	n occurred vestigation	at the time n, in my op	e, date and pinion, deatl	d place, ar h occurre	nd due to the d at the time,	cause(s) a date and p	ind manner as place, and due	stated. to the	cause(s)	
	To the within 2 To the comple	M	29b. Signature and title of certifier			29	c. License					signed (Monti			
,			30. Name and address of person who com	pleted cause of death (Ite	n 23a) (Type,	Print)	0.	C.M.E			Octo	ber 31	, 20)05	_
			AMA RUBI	0,10				enn S	tree	t Balı	timor	e, Mar	ylar	nd 21201	
A.	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Sign	M. A	mile									

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		1 - State Registrar Amend Item 25ate	per-Maryland 49	Partornoghibealth and Certificate of Death	Mental Hygiern	005 35781				
Physi	cian	Decedent's Name (First, Middle, Last)	Ludio	0	2. Date of Death Month Date	3. Time of Death				
/Med	lical	4a. Facility Name (If not institution, give street and		4b. City. Town, or Location of Deal	DOLLING!	County of Death				
Exam	iner	Future Care Charles V		Baltimore		,				
Funera Directo		5. Social Security Number 6. Sex 1 M 2 1 M 2 1 M	7. Age (In yrs. last birtho	day) If Under 1 Year If Under 24 Hrs		9. Birthplace (State or Foreign Country) Maryland				
and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	or Location		10d. Inside City Limits				
Maryl -f sho	to	MD	Balt	imore		1 Yes 2 No				
h the	Director	10e. Street and Number		10f. Zip Code	10g. Cit	izen of What Country?				
23e c	al D	3034 Keswick Road		21211		USA				
ING 21213-UU36 be filed within 72 hours after death with the Maryland stal Hygiene. Id other then "netural; or items 23e or 28e-f show event, the Medical Every activities at	by Funeral	1 Never Married 2 Married 1 Yes,	Forces? es 2 ☑ No	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: white				
2 hou	ted	15. Decedent's Education	16a. D	ecedent's Usual Occupation	16b. K	ind of Business/Industry				
	Completed	(Specify only highest grade complete Elementary/Secondary (0-12) Colleg	e (1-4or 5+)	Give kind of work done during most of wo ife. DO NOT use retired)	nking					
laryland 2121 2 should be filed within and Mental Hygiene. Is marked other then aumatic event, In Men	Con	5 0		disabled		one				
be fill half H and out	Be	17. Father's Name (First, Middle, Last)		ann	me (First, Middle, Maiden velyn Smith	First, Middle, Maiden Sumame) Ivn Smith				
Maryland d 2 should be file th and Mental Hy 7 Is marked oth	To	19a. Informant's Name/Relationship (Type, Print)	ural Route Number, City	or Town. State. Zip Code)						
and 2 seath and 2 seath and 27 is ner traus		Josephine Gear/sister		34 Keswick Avenue						
S = = = =		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from the second secon	20b. Place of Cometery,	Disposition (Name of crematory or other place)		ocation - City or Town, State				
Baltimo permit. Pages Department of Important: If i		21. Signature Funeral Service icensee Ronald Wade,		22. Name and Address of Facility State Anatomy Boar Baltimore, MD 21	d 655 W. Bai	ltimore Street				
Physicia		shock, or heart failure. List only one cause of immediate Cause (Final disease or condition a	on each line.	t enter the mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between Onset and Death				
/Medica Examine	r .	Se uentially list conditions, b.	to (or as a consequence of Liver 1	Pailure						
58760, ficate be executed physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	Hepatit to (or as a consequence of	tis C						
68760, tificate be ex g physician as the burial	ledicat	d								
I Records, P.O. Box 6 The law requires that the death certific ate has been signed by the attending I bage 2 should be detached for use as	by Physician/M	in the past 12 months?	outcome of pregnancy ve birth 2 Fetal death regnant at time of death nknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year				
cords, P. w requires that been signed by		Part II. Other significant conditions contributing	to death but not resulting in t	he underlying cause given in Part I.		use contribute to the cause of death?				
	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No				
of Vital F Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?		Othor	eath (Check only one)					
Of O Physi rthis o	2	1 Yes 2 No	☐ Inpatient 2☐ ER/Outp ate of Injury 28b. Tir	patient 3 DOA Nursing	Home 5 Residence 28d. Describe how inju					
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or Atten or Atten after deat Diractor: in by the	Certification:	3 Suicide 6 Could not be 28e. P	lace of Injury - At home, famuilding, etc. (Specify)	n, street, factory, office	28f. Location (Street ar City or Town, State	Location (Street and Number or Rural Route Number, City or Town, State)				
tha Hospital in 24 hours a tha Funaral I	edical C	(Check only 2 Medicel Exeminer: On the		death occurred at the time, date and place for investigation, in my opinion, death occ						
To the within To the comp	×	29b. Signature and title of certifier	mo	29c. License number		ite signed (Month, Day, Year)				
		30. Name and address of person who completed	parties phone	ype, Print) OVIN CHAYLES!	Street Bal	timore marylan				
Regi	State strar	NOV 0 7 2005	De M. Age	We						

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Please Type or Print in Black Indelible Ink. Ensure All Coples Are Legible.

Amend item 5 per fh 2852 2-22-06 vt State of Maryland Department of Health and Mental Hygiene 6 5 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Vear **Physician** 700A M Shinley 2005 November, /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Paltimore Parhville Facility Parkway Narm If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. S216-34+9418 6. Sex **Funeral** 1□ M 2**X**F Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinar must be notified at 1 Kes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and N 3 Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in Armed Forces? Black 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) ollege (1-4or 5+) 18. Mother's Name (First, Middle. Father's Name (First, Middle, Last) To Be Mental 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20744 Important: If item 27 Is any injury or other training 0009. 20b. Place of Disposition (Name of Date 20c. Location - City work own, State Disposition Burial 2 Cremation 3 □Removal from State Donation 5 Other (Specify) ure of Funeral Service Licensee 21. Signa 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) microbial Physician /Medical Due to (or was a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): noing physician a Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months?
1 ☐ Yes 2 ☑ No to o 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown is been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Toknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 210 No certificate 2 No 1 Yes Be (25. Was case referred to medical 26. Place of Death Check onl. one examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 1 X Natural 5 Pending 1 Tyes 2 🗆 No death. investigation 2 Accident the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d To the Funeral Direct completely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of gettifier D0059423 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Good Sa Prof Building #303 Feinberg phariteen Hospital 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 0 2005

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State of Maryland / Department of Health and Mental Hygie e 0 0 5	3578
Certificate of Death Reg. No.	

			1 - State Registrar	(Certificate of Death	Reg. N	No.	
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	1c mickens		2. Date of Death	Day Year 5, 2005	3. Time of Death S: OSA M
	Examir		4a. Facility Name (If not institution, give s		4b. City, Town, or Location of D	11 . 0 =	4c. County of Death	A
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last birth	day) If Under 1 Year If Under 24		ar) Col	nplace (State or Foreign unity)
	death with the Maryland ms 23a or 28a-f show f must be notified at	Director	10a. State 10b. County MARILAND 10e. Street and Number	A 10c. City, Town	Or Location BALTIMO 10f. Zip Code	RE CITY	Citizen of What Co	10d. Inside City Limits 1 □ Yes 2 □ No
	death with	Funeral Dir	1810 MOS	HER STREE 2. Was Decedent Ever in U.S.		17	USA 14. Race - Amer	rican Indian,
9000	72 hours after natural', or ite dical Exemine	þ	1 □ Never Married 2 💢 Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:			LACK
121215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan 1 of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28e-f show other traumatic event, Ira Madical Examiner must be notified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) (Decedent's Usual Occupation Give kind of work done during most of life. DO NOT use retired) PRESSER	working D		NING Co.
Maryland	should be fill and Mental H marked off	To Be	17. Father's Name (First, Middle, Last) TESS/E 19a. Informant's Name/Relationship (Ty)	MC L		Name (First, Middle, Maid RAH Rural Route Number, Cit	RI	7 1/
	Health an tem 27 is i		TO MMY MCMICKEN 20a. Method of Disposition	(HUSBAND)	810 MOSHER Disposition (Name of	2 ST. B.	ALTO, H Location - City or 1	1021217
Baltimore,	permit. Pages Department of Important: If It any injury or o		2 ☐ Cremation 3 ☐ River 4 ☐ Donation 5 ☐ Other (Specify) 21. ign hure of Fune 1 ervice License	emoval from State	ISON FOREST (1) 22. Name and Address of Facility TO SE PH H TO 40	-14-05 Oc.	UINGS I	MILLS MD, LERAL HOME
	Physician /Medical	(23a. Part1. Enter the disease, or complications, or heart failure. List only on the sease or condition disease or condition resulting in death)	e cause on each line. Myocardial I	nt enter the mode of dying, such as car		5/12/0, /	Approximate Interval Between Onset and Death
	Examiner	er	Sequentially list conditions, if any, leading to immediate	Due to (of as a consequence of				
68760,	certificate be executed ding physician and ise as the burial-transit	cai Examiner	cause. Enter Underlying Cause (Disease or injury) that initiated events resulting in death) Last	Due to (or as a consequence of):			
.O. Box 68		Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	23d. Date of delivery Month Day Year			
<u>α</u>	The law requires that the death tie has been signed by the atter bage 2 should be detached for u	by	Part II Other significant conditions con	tributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacci	_ /	the cause of death?
of Vital Records,		Completed	Olazulopathy.			24a. Was an autopsy performed? 1 \(\text{Yes} \) 2 \(\text{ZL} \).	prior to c death?	topsy findings available ompletion of cause of 2 No
V	siclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:	Othor	Death (Check only one)		
on of	G is.	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. Ti	patient 3 DOA 4 Nursin	g Home 5 Residence 28d. Describe how in		ify)
Division	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Street City or Town, Sta		ral Route Number,
	the Hospi in 24 hour the Funer pletely fill	edical	(Check only) 2 Medical Examin	ician: To the best of my knowledge, ner: On the basis of examination and and manner stated.	death occurred at the time, date and ploor investigation, in my opinion, death o	ccurred at the time, date a	and place, and due	to the cause(s)
)	withi Tot com	Σ	29b. Signature and title of certifier	reducaltius of con	29c. License number	Α.	Pate signed (Month	
_			30. Name and address of person who co	mpleted cause of death (Item 23a) (T	street Baltimon	10, Moryland	21223)
	Sta		31. Date filed (Month, Day, Year)	32. Begistrar's Signature	Anastel			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 620 AM NOVENBER ELIZABETH MCDUFFIL 2000 2 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death C177 BALTIMORE HOSPITAL BON SECOURS If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Months Days 1□M 200 F 03-10-1928 NORTH CAROLINA 212-30-8136 Yrs. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 Yes 2 □ No TIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA MILIVER STREET 21213 2326 EAST 12. Was Decedent Ever in U.S. Armed Forces 1 | Yes 25 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 ☐ Married Specify: BLACK 1 ☐ Yes 22 No 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) RIVATE DAYCARE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) McDUFFIE RADDIE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) OLIVER ST. BACTIMORE, MD. 21213 INNIE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 CEMETERY NOV. 7, 2005 BALTO, MD.
22. Name and Address of Facility PHILLIPA WEATHER FORD FUN STAPA Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee

23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on 57. nat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sudden Cardina disease or condition resulting in death) Due to (or as a consequence of): Plesume Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Porkinsunism, Mulyutrition 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed) 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical **Examiner** attending physician and for use as the burial-transit The law requires that the death certificate be executed Box 68760. Division of Vital Records, P.O. detached

Physician

/Medical

Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Intermed of Health and Mental Hygiene. Intermed of the than "natural", or Items 23a or 28a-f show

permit. Pages 1 and 2 should be filed w Department of Health, and Mental Hygies Important: If item 27 is marked other til any injury or other traumatic event, "It once."

21215-0036

Baltimore, Maryland

the Medical Examiner must be notified at

Director

Be Completed by Funeral

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Examiner

Physician/Medical

Be

2

this

e Hospital or Attending Phys 24 hours after death. e Funeral Director; After this letely filled in by the funeral di

within 24 hours a To the Funeral C

that initiated events resulting in death) Last Completed 1 ☐ Yes 2 ☐ No 27. Manner of Death

1 Natural

2 Accident

3 🗌 Suicide

4 Homicide

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

BALTIMORE,

29a. Certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

determined

MD

30. Name and odress of person who completed cause of death (Item 23a) (Type, Print)

10062634

NoV

State

Registrar

31. Date filed (Month, Day, Year) NOV 0 7 2005

MATGEN AWAN

HAMMONDS 2717 32 Registrar's Signat 8 3 3 B. J

FERKY RD

Patricia Mokros 05-07364 NJM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiette O IT

			1 - State Amend Item 4		tem 23a&27	per me G84 rtificate of Dea			No.	35785
	Physici	an	Decedent's Name (First, Middle, Last	t)	Patricia	Mokros	, A		Day Year	h A
	/Medic Examir	- 45	4a. Facility Name (If not institution, give	street and number)	Facilitia	4b. City, Town, or Loca		rember	1 2005 4c. County of Dea) 1135
-	LAGIIII	C1	6816 Boston Aven	ue		Baltimore			Baltin	more Co.
	Funeral Director		213-54-4603	□M 2XF	(In yrs. last birthday) Yrs.	If Under 1 Year If U	Inder 24 Hrs. 8. D	ate of Birth Month, Day, Yea uly 21,	4	rthplace (State or Foreign Country) Lryland
	death with the Maryland ms 23a or 28a-f show must be notified at		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	ter death with the Marylan Items 23a or 28a-f show fret must be notified at	Director	Maryland L	timore		Dı	undalk			1 ☐ Yes 21 No
	or 24	Dire	10e. Street and Number			10f. Zip Code		10g.	Citizen of What C	Country?
	s 23s	e a	6816 Boston Ave	nue 12. Was D <i>e</i> cedent E	wor in II S 12		222		nited St	
36	or ite	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	Armed Forces? 1 Yes 25 No If Yes, Give Year or Dates:	0	Was Decedent of Hispan If Yes, specify Cuban, Me 1 ☐ Yes XX No Sp	exican, Puerto Ricar	n, etc.)	Black, Wh	
15-00	"natural",		15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Give	dent's Usual Occupation kind of work done during DO NOT use retired)	g most of working	16b	. Kind of Business	
Maryland 21215-0036	2 should be filed within 72 h and Mental Hygiene. Is marked other than "natu aumatic event, It a Medical	Completed	Elementary/Secondary (0-12) 12 Years	College (1-4or 5+	+)	ata Entry /	Clerical		Martin M	arietta
ī		Be	17. Father's Name (First, Middle, Last)				Mother's Name (Fire			
ž	hould d Men marke matic	မ	Leonard J. Pol 19a. Informant's Name/Relationship (OY 19h Maili	ng Address (Street and N	Helen R. I			Zin Code)
<u>s</u>	s 1 and 2 should I Health and Mer Item 27 is merke other traumatic		Mr. Leonard J.			D Bank Stree		nore, Ma	•	21224
re,	s 1 and 2 if Health Item 27 other tra		20a. Method of Disposition		20b. Place of Dispo	osition (Name of matory or other place)	Date		Location - City o	
Ē	Page nent o ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		1	wn Cemetery	1/5/2009	5 1	Baltimor	e, Maryland
Baltimore,	permit. Pages 1 ar Depertment of Hea Important: If Item eny injury or othe		21. Signature of Funeral Service Licer	see J	I	2. Name and Address of Ouda-Ruck Fu 922 Wise Ave	neral Hor	me of Du lk. Mar	ındalk, vland 2	Inc. 1222
N			23a. Pa 11. Enter a disease, or com sho k, or heart failure. List only	olications that caused tone cause on each line	the death. Do not en			The state of the state of the state of		Approximate Interval Between Onset and Death
29	Physician /Medical Examiner	ر	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	Due to (or as a	consequence of):	rdiovascular	Disease			
•	icate be executed physician end s the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	consequence of):					
68760,	icate be e physiciar s the buri	edical	(d						
P.O. Box (Hospital or Attending Physician: The law requires that the death certificate be executed 4 hours efter death. Funeral Director: After this certificate hes been signed by the attending physician end teneral Director: After this certificate Seen signed by the attending physician end tell filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 D No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at t	Petal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	elivery Day Year
	v requires that the been signed by should be detact	ğ	Part II. Dther significant conditions of	ontnbuting to death bu	t not resulting in the u	underlying cause given in	Part I.		· /	to the cause of death? Probably 4 □Unknown
Division of Vital Records,	The law re ate hes bee	Completed						24a. Was an autopsy performed 1 Yes 2	24b. Were a prior to death?	autopsy findings available completion of cause of
ita	sian: Brtifica Ictor, I	Bec	25. Was case referred to medical examiner?			26.	Place of Death (Ch			
o o	g Physician: The la er this certificate he eral director, page 2	2	1 XYes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatier 28a. Date of Injury (Month, Day			Nursing Home 28d.	5 Residence		ecify) Scene
visior	To the Hospital or Attending I within 24 hours effer death. To the Funeral Director: After completely filled in by the funer	Certification:	1 XNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined		ry - At home, farm, st	M 1 ☐ Yes	28f. L	ocation (Street	and Number or F	Rural Route Number,
	pital or ours efte eral Dir filled in					th accurred at the time of				
	To the Hospital or Attent within 24 hours efter death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Examone)	vsician: To the best of niner: On the basis of and manner state	examination and/or in	th occurred at the time, danvestigation, in my opinior	n, death occurred at	the time, date	and place, and du	ue to the cause(s)
,	With To	2	29b. Signature and title of certifier	1		29c. License nun	nber		Date signed (Mor	
	\sim		30. Name and andress of person who	completed cause of de	eath (Item 23a) (Type	OCME		Nov	vember, 2	2, 2005
			31. Date filed (Month, Day, (ear)	arport	nD.	111 Penn	Street 1	Baltimo	re, Mary	land 21201
	Sta Regist		SI. Date-filed (Molifit, Day, Gaz)	05 Hosen	r's Signature	-				

State of Maryland / Department of Health and Mental Hygiege 05 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Mildred Michelman 3, 2005 9:30 a. November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 3200 Holly Knoll Court Abingdon Harford Co. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Dec. 4, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗙 F 218-09-9267 88 Yrs. Director Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 27 is marked other than "natural", or Items 23a or 28a-f show treumstic event, tre Madical Examinar must be notified at 1 ☐ Yes 2 No Abingdon Directo Maryland Harford Co. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3200 Holly Knoll Court 21009 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Iter any injury or other treumatic event, the Medical Examinan once. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 8 yrs. College (1-4or 5+) Baltimore City Schools Crossing Guard 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frank Bliss Virginia Cooper Dorsev Laura 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mary V. Pape - Daughter 3200 Holly Knoll Court Abingdon, Maryland 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Nov. 7, 2005 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 21. Signature of Funeral Service Lie Michael E. Canapp 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Heart congestive disease or condition resulting in death) /Medical Due to for as a consequence of). **Examiner** Due to () r as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 ☐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA s after death.

I Director: After this of in by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 24 hours a 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the Hosp within 24 ho To the Fune completely fi and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) D41968 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nottingham, MD 21236 7602 Belair Road MARTIN, MYD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 5 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Menth Year 05 George MENTIS 2005 :âOA" /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimor 7. Age (h yrs. last birthday) KOJE DE Sex Ale If Under 1 Year Birthplace (State or Foreign Country) **Funeral** 10M 20F 213-80-6344 Director Yrs. Girecce Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside Çity Limits "naturel", or Iteme 23a or 28a-f ehow the Medical Examinar must be notified at 1 Yes 2 No Baltimore Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 610 21224 USA Was Decedent Ever in Armed Forces?

1 Yes 2 No tf Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 21215-0036 2 No Specify. þ Specify: white 3 ☐ Widowed 4 ☑ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOTuse retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na eny Injury or other treumatic event, The Madia. 2006. Elementary/Secondary (0-12) College (1-4or 5+) Manknance Painter Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Greorgion MENTIS 0/205 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hombers Balto SON mi Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Greek Orthodox Cemekry 8 4 □ Donation 5 □ Other (Specify) 05 Name and Address of Facility

Bradly - Askton 21. Signature of Funeral Servi & Licens, e Nome, P.A. radicy-Ashton, was Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consacuence of ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 0 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? res 22No this certificate ! 1 ☐ Yes completely filled in by the funeral director, 25. Was casa referred to medicat examiner? 26. Place of Death | Check only one Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural After ! 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 5 Pending Injury 1 Yes 2 No death. To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident investigation 3 🗀 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JING

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000

32. Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

D0063216

29d. Date signed (Month, Day, Year)

Square Drive Baltimore MD 21237

			For State Registrar	State of Maryl	and / De	epartmer Certificat	nt of He e of D	ealth a Death	nd Me		ierne ()	05	357	88
· car	740 Az		1. Decedent's Name (First, Middle, Last)						2.	Date of Deat Month	Death 3. Time of Death			
1	Physicia /Medic		Lloyd W. Miller							October	per 31 2005 1558			PM M
rii -	Examin	er	4a. Facility Name (If not institution, give s			4b. City, Town, or Location of Death 4c. County of Death								
74	<u> </u>		400 Millington Aver		rs. last birtho		ltimo	re If Under 2	4 Hrs. o	Date of Birth		9 Birthr	olace (State o	or Foreign
	Funeral Director		5. Social Security Number unk 6. Sex		79 Yrs	Months		Hours	Min.	(Month, Day,		Cour	ntry)	unk
(10)	70.0		Usual Residence of Decedent						,01	CL 179	1720			
	ylanc		10a. State 10b. County	10c.	City, Town o	or Location						1	0d. Inside C	
	8 Ma	ctor	MD		Baltin	nore								2 🗆 No
	or 28	Director	10e. Street and Number			10f. Zi	p Code			11	0g. Citizen o	of What Cour	ntry?	
	hours after death with the Maryland turel', or Iteme 23e or 28e-f show al Examiner must be notified at		400 Millington Ave		-110	10 144 - D -		1223	:-0 /C4	V N-	14 8	USA	an Indian	
	er de Item	Funeral	11. Marital Status unk 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 ☐ No	unk	13. Was Dece If Yes, spe	cify Cuban	, Mexican,	Puerto Ric	an, etc.)		lace - American Indian, Ilack, White, etc.		
36	I', or	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2 X No	Specify:			Specify: black			
21215-0036	CI O		15. Decedent's Edu			ecedent's Usu			of working	unk	16b. Kind of	of Business/Industry unk		unk
215	_ z :30	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	- 'ii	Give kind of wi ife. DO NOT u	ise retired)	iring most	or working					
	filed within Hygiene. other than	Completed	unk un	k			1							
pu	d ta b	Be	17. Father's Name (First, Middle, Last)				unk	18. Mother	r's Name (F	First, Middle, M	Maiden Sum	iame)		unk
Maryland	should be ind Mental marked c	မှ		Dial	40h A	An Illinois Audelinois	- /Ct t	and Alexandra	a a a Dural C	Touto Alumbara	City or Tou	um Ctato Zie	Codol	
Mai	2 d d d d d d d d d d d d d d d d d d d		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 19c. M.E. 111 Penn Street Baltimore, MD 21201									Code	1	
	Heeling	1	O.C.M.E. 20a. Method of Disposition	20	b. Place of D	isposition (Na	me of		Dat			n - City or To	own, State	
nor		1	1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 【 Qther (Specify)		cemetery,	crematory or	other place	"						
Baltimore,	permit. Page Department Important: If any Injury or once.		21 Signature of Funeral Penvice Liceus	CONTRACTOR CONTRACTOR		22. Name a	nd Address	s of Facility	у .	655 W.				
Ba	Dep Pure Pure Pure Pure Pure Pure Pure Pure	. 4	mont of	ade Direct	or	State Baltin			oard (21201	655 W.	Balti	more S	street	
	25	0	23a. Part. Enter the disease, or complished or heart failure. List only or	cations that caused the	death. Do no				cardiac or r	espiratory arre	est,		Approxima Interval Be	te tween
	Physician		Immediate Cause (Final disease or condition	1 de si	clea	tic (الله المحمد	A-1 C (a	la-	Dise	e ia		Onset and	
	/Medical		resulting in death)	Due to (or as a cor	sequence of)):	7	Visitor	- Ψγ	D . G .	- The		<u>-</u>	
1	Examiner		Sequentially list conditions,)										
	be tis	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	isequence of)):								
	sicien and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a cor	sequence of)):								
8760,	law requires that the death certificate be executed es been signed by the ettending physicien and 2 should be detached for use as the burial-transit	dical E	L.	•										
687	ificate g phys as the	edic		·										
ŏ	leath certific ettending pl	M	IF FEMALE: 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy								23d.	23d. Date of delivery		
œ.	ne death the ette hed for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time		5 Other (s						Month	Day	Year
P.0	at the de by the	hys	9 Unknown						-		1.			
	res tha igned l be det	þ	Part II. Other significant conditions con	ntributing to death but no	resulting in t	he underlying	cause give	n in Part I.		23e. Dia tot	A	ontribute to t		Unknown
ord	w requir been si should	ted	Moseres 1	ne 111100					_		-			
Records,	e law hes b	Completed					·			24a. Was a autops perform	y	b. Were auto prior to co death?	psy findings impletion of a	available cause of
E F	ਜੂ ag gg										No	1 ☐ Yes	2 □ No	
of Vital	Physician: T this certificet ral director, pa) Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient	2 ER/Outp	estinat 200	Othe			Check only on 5 ☐ Reside		Dthan /6	4.) Co.	
o		. To	27. Manner of Death	28a. Date of Injury	28b. Tir	ne of	28c. Injury Work	4 🗀 Nu		d. Describe ho			y scer	ıe
on	Attending r death. sctor: After by the fune	to	f Accident 5 Pending investigation	(Month, Day Yea	ir) Inji	ury M		? ′es 2 □1	No					
Division	Attendi sr death ector: / by the fi	Hick	3 Suicide 6 Could not be 4 Homicide determined	n, street, facto	ry, office		28	f. Location (St City or Town	reet and Nu	mber or Run	al Route Nur	nber,		
Ö	tel or s efte al Dir	28a. Date of Injury 28b. Ime of least survey 28d. Describe how injury occurred												
	To the Hospitel or Attent within 24 hours effer deating the Euneral Director: completely filled in by the	29a. Certifier (Check only and due to the cause(s) and manner as stated. 29a. Certifier (Check only and due to the cause(s) and manner as stated. 29a. Certifier (Check only and due to the cause(s) and manner as stated. 29a. Certifier (Check only and due to the cause(s) and manner as stated.											s)	
	and manner stated. 29c. License number 29d. Date signed (Month, or signed in the first signed in the firs										Day, Year)			
	⊢ < ⊢ ō		IN Janko	M			0.C.I	M.F.			Novemb	er 1,	2005	
			30. Name and address of person who co	ompleted cause of death	(Item 23a) (T	ype, Print)	0.0.1				LIO V CIIIL	~ <u> </u>	2007	
_			J- LARON LOU	ce mo		1.	l1 Pei	nn St	reet	Baltim	ore, N	Maryla:	nd 212	201
18		ate	31. Date filed (Month, Day, Year)	32. Registrar's S	Signature	Sociale	,							
	Regist	rar 💮	N11V V (40	UJ EDVERAGE	A.S.	Carlotte State of the State of								

State of Maryland / Department of Health and Mental Hygiene 0 0 5 1 - For State Ragistrar 35789 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2005 ear **Physician** November 5, Sernocky Oberholtzer Arlene 6:40 p M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Towson Gilchrist Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Days January 17, 1948 1 ☐ M 2 🔀 F Months 57 215-50-4250 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County ייו ושנון בין ושמאמס other than "natural", or items 23a or 28a-f ahow or other traumatic avant. the Madical Examilian נוטומן גם הטוווים ב 1 Yes 2 No MD Baltimore Lutherville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11704 Mayfair Field Drive 21093 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 20 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Itimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) se filed within 7 al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Seminary Conference Coordinator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be f and Mental h is marked of Padnuk Peter Sernocky Neena Joseph ဂ permit. Pages 1 and 2 shc.
Department of Health and N.
Important: If item 27 is many injury or other 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11704 Mayfair Field Dr., Lutherville, MD 21093 Dean L. Oberholtzer-husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Hilltop Service Corp 11/7/05 Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service William G. Dau 22. Name and Address of FacilityRuck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) nodakuns ars **Physician** /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ettending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical Oberholtzes Aplene IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was an autopsy performed?
Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death | Check only one examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred the Hospital or Attending 1 Natural 2 Accident Injury 5 Pending death investigation Director 6 Could not be determined 3 Suicide 28 e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2.a Carther Medical (Check only within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 uno pleted cause of len h (Item 23a) (Type, Print) Nam and address of person 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 Registrar

			For 1_ State	State of Maryland	d / Departme		-	_	35790
S			Registrar		Certifica	ate of Death	Reg.	No.	
	Physici	an	1. Decedent's Name (First, Middle, L	\circ 1			2. Date of Death	Day Year	
	/Medic		4a. Facility Name (If not institution, g	ive street and number)		ity, Town, or Location of Deal	- W	2 2003 4c. County of Dea	
	Examin	ier	Gilchnist	Hospice	40.0	Bald		Balto	
	Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs. la		der 1 Year If Under 24 Hrs	8. Date of Birth	9/Bji	rthplace (State or Foreign
	Director		217-20-3679	10 M 25 84	Yrs. Month	ns Days Hours Min.	Oct 4, 19	and U	ountry) and
γ _	and		Usual Residence of Decedent 10a. State 10b. County	10c. City	/. Town or Location				10d. Inside City Limits
2	Maryl f sho	ō	41 616	'	salto.				1 No 2 No
2	28a-	Director	10e. Street and Number	, ,,		Zip Code	10g.	Citizen of What C	ountry?
	h with	je D	1734 h. Be	Aglou St.		21216		U.S.A	
oJ.	ma ?	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. Was De	cedent of Hispanic Origin? (Specify Cuban, Mexican, Puer	ipecify Yes or No-	14. Race - Am Black, Whi	erican Indian,
1 m	or it		1 Never Married 2 Married	1 ☐ Yes 2/M No If Yes, Give		2 No Specify:	to Theatt, 6to.)	Specify: 13	
5-0036	within 72 hours after death with the Maryland ene. than "natural", or itema 23a or 28a-f show the Madical Examiner must be motified at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:					
	in 72	Completed	15. Decedent's (Specify only highest g	rade completed)	16a. Decedent's U (Give kind of life. DO NO	work done during most of wo	rking	. Kind of Business	Mindustry
212	filed withi Hygiene. other than	шо	Elementary/Secondary (0-12)	College (1-4or 5+)	11	naker		ames	t/c
	be filed tal Hygie d other	Bec	17. Father's Name (First, Middle, Las	it)			me (First, Middle, Maid	fen Sumame)	
ya.	Mental Mental arked o	To	Andrew Jon	د ع		Martha	Oliva		
Maryland	2 sho		19a. nformant's Name/Relationship	(Type, Print)	19b. Mailing Addre	ess (Street and Number or Ri	ural Route Number Cit		
0.1	1 and fealth am 27		20a. Method of Disposition	wder daughter	ace of Disposition (A	· Bentalou	Date 20c		. 21216
g 4	Pages nent of t int: if its iry or of		1 ☐ Burial 2 ☐ Cremation 3	☐Removal from State	emetery, crematory o	or other place)	200	Location - City or	Town, State
Artimore,			4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lic	المستدار ا	1 to Came	tery NOV	7 2005 E	app, pr	0.4
Ba	permit. Departimport Import eny inj		X geston C	Dunla	Carlo	on a. Pouglas	Buneral	Service	V.75.
	3 T.A. A.		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the death	. Do not enter the m	node of dying, such as cardia	or respiratory arrest,	1.40	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	a Metastano		The state of the s	nown prin	>	Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ	- New Williams	or or one	and better	rouse	contrary
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	ted sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	ence of):				
,	be executed ician and burial-transit	xar	that initiated events resulting in death) Last	c. Due to (or as a consequ	ence of):				
260	eath certificate be executed attending physician and for use as the burial-transit	cai		d.					
68	certificat iding phy ise as th	0-00000							
Вох	th cer lendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar 1☐Live birth 2☐Fetal		nregnancy		23d. Date of de	livery
	0 0 0	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of de 9 Unknown				Month	Day Year
P.0	hat th d by i	Phy	Part II. Other significant conditions	contributing to death but not recu	ulting in the undertwise	o course owner in Flort I	220 Did tobaco		a the cause of death 0
ds,	The law requires that the death Ite has been signed by the atte bage 2 should be detached for	1 by	Tartii. Still significant conditions	contributing to death but not resul	ining in the andenying	g cause given in Part I.	1 Tes		o the cause of death?
Ö	w require been si should l	ete						-,	
Re	sicien: The law scertificate has b lirector, page 2 s	Completed					24a. Was an autopsy performed	prior to	topsy findings available completion of cause of
Ta I	an: T liftcate or, pa		25. Was case referred to medical			26 Diago of Day	1 ☐ Yes 2 ☑ Ith (Check only one)	Vo 1 ☐ Yes	2 □ No
Ξ	ding Physician: The I h. After this certificate ha funeral director, page	To Be	examiner? 1 □ Yes 2 ZNo	Hospital:	ER/Outpatient 3	Othor	ome 5 Residence	6 Other (Spe	city haspile.
0	ng Ph Iter th neral		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how in		
sio	eath. or: A	catic	2 Accident investigati	on	М	1 ☐ Yes 2 ☐ No			
Division of Vital Records,	or Ati	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, street, fact)	ory, office	28f. Location (Street City or Town, St	and Number or Reate)	ural Route Number,
	To the Hospital or Attanding within 24 hours after death. To the Funaral Director: After completely filled in by the fune		29a. Certifier Certifying F	Physician: To the best of my know	viadae death coor	ed at the time, date and aller-	and due to the	(a) and	atasa d
	P Fur	Medical	one) 2 Medical Ext	and manner stated.	ion and/or investigati	on, in my opinion, death occu	rred at the time, date a	ind place, and due	to the cause(s)
	To th withir To th comp	M	29b. Signature and title of certifier	0		29c. License number	29d. [Date signed (Mont	h, Day, Year)
	~		Alla	lus		D57303	No	vember	3 2005
4 17	7		30. Name and address of person who	completed cause of death (Item	23a) (Type, Print)	D58303	MD 71706	L	
10			31. Date filed (Month, Day, Year)	32 Registrar's Signatu	ure .	1 100001	1 2/00	Ī	
14	Sta Registra		NOV 0 7 20	105		,			

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Maryland / D	Department of He Certificate of D		Hygien Reg. N	. 000	35791
Per	* Physici /Medic		1. Decedent's Name (First, Middle, Last)	RICHAN	ruson	2. Date of Month	Da Da	ay 2005	3. Time of Death
}	Examin Funeral Director		2.2 00 0031	7. Age (In yrs. last birt	7	COURT, RHICK I	of Birth		
	laryland show	٥٢	Usual Residence of Decedent 10a. State 10b. County Maryland Carroll	10c. City, Town Elde	n or Location rsburg		•		10d. Inside City Limits 1 ☐ Yes 2√2 No
	vith the N or 28a-f be notifi	Director	10e. Street and Number		10f. Zip Code		10g. C	itizen of What Co	
36	d within 72 hours after death with the Maryland jiene. r than "naturel", or Items 23a or 28a-f show the Medical Evantiner must be notified at	by Funeral	6235 Oakhill Dri 11. Marital Status	. V ⊖ . Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	21 7 8 decedent of His lf Yes, specify Cuban	4 panic Origin? (Specify Yes o Mexican, Puerto Rican, etc. Specify:	r No-	SA 14. Race - Amer Black, White spaily a CK	e, etc.
21215-0036	l within jiene. r than "	Completed	15. Decedent's Educat (Specify only highest grade of	ion ompleted) 16a. College (1-4or 5+)	Decedent's Usual Occupat (Give kind of work done du life. DO NOT use retired) Homemaker	ion ring most of working		Kind of Business/I	ndustry
Maryland ?	be filed tal Hyg d othe event,	To Be C	17. Father's Name <i>(First, Middle, Last)</i> James Benjamin F			18. Mother's Name <i>(First, Mi</i> Carrie Day	ddle, Maidei	n Sumame)	
	nd 2 suith ar		19a. Informant's Name/Relationship (Type Alvin Richardson	Print) 19b.	Mailing Address (Street ard 6235 Oak)	nill Drive	Imber, City Eldei	or Town, State, Z	^{ip Code)} 21784 Marvland
Baltimore,	Page: ent o nt: If ry or		20a. Method of Disposition 1	20b. Place of cemeter	Disposition (Name of y, crematory or other place) Ridge Ceme	Date 11/2/05	20c. L	ocation - City or	
Ball	permit. Departm Importe eny inju		21. Signature of Funeral Service Licensee		22. Name and Address 5240 Reist	^{of Facility} Chatman terstown Rd	n-Har Balt	ris Fu	neral Home Md 21215
	Medical Examiner	Examiner	23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, flan, Laong to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the to (or as a consequence of	e in fare	such as cardiac or respirato	ry arrest,		Approximate Interval Batween Onset and Death
O. Box 68760,	ne death certificate be executed the attending physician and thed for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of deli-	very Day Year
rds, P.O.	law requires that the deas been signed by the 2 should be detached	by	Part II. Other significant conditions contri	^	n the underlying cause giver		. «		the cause of death?
al Records,	The ate his page	Completed				1XV	Mas an autopsy performed?	prior to co	opsy findings available ompletion of cause of 2 No
f Vital	Physicien: 1 r this certificat ral director, p	To Be	25. Was case referred to medical examiner? 1 \(\sum \text{Yes} \) 2 \(\sum \text{No} \) Hos	pital: 1 X Inpatient 2 □ ER/Out	Other	26. Place of Death (Check of 4 Nursing Home 5 F		6 □Other (Spec	ify)
o uoi	ding h. After fune		27. Manner of Death Natural 5 Pending Accident investigation		ime of 28c. Injury a Work?	at 28d. Descr es 2 \(\subseteq No	ibe how inju	iry occurred	
Division of	of or Attendi after death. I Director: A d in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, office	28f. Location City of	on (Street ar Town, State	nd Number or Rui e)	ral Route Number,
	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edical	29a. Certifier (Check only one) Certifying Physic 2 Medical Examiner	ian: To the best of my knowledge : On the basis of examination and and manner stated.	, death occurred at the time d/or investigation, in my opin	, date and place, and due to nion, death occurred at the ti	the cause(s me, date an	s) and manner as d place, and due	stated. to the cause(s)
)	To the within com	Σ	29b. Signature and title of certifier	Mo.	29c. License	number 977	29d. Da	ber 31	
1	\		30. Name and address of person who comp	oleted cause of death (Item 23a) (Type, Print)	e wo.	2106	21.	
E.	Sta Registr		NOV 0 7 2005	32 Registrar's Signature	Spark				

			1 - For State Registrar	e of Maryland / De	partment of Certificate of	Health and Death		iene 0 0	5 357	92
	Physic	on	1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month	Day	3. Time of [Death
	/Medi			cille			Nov. 1	, 2005	4:15	Рм
5	Examir	ner	4a. Facility Name (If not institution, give street an	d number)	_	or Location of Deat	h	4c. County of		
			7003 Martha Avenue 5. Social Security Number 6. Sex	7. Age (In yrs. last birthd		emere	O Data of Bigh		timore Co.	
н	Funeral Director		1 3 cM 2 □	IF Ven	Months Days			Υθar)	9. Birthplace (State or Country)	roreign
			212-34-5837 Usual Residence of Decedent	68			sept.	1,1931	Maryland	
	nylan how		10a. State 10b. County	10c. City, Town or	r Location	_			10d. Inside City	y Limits
	e Ma	cto	Maryland Baltimo:	re		Edgem	ere		1 Tes	2 ⊘ 4No
	ith th	Dire	10e. Street and Number		10f. Zip Code		1	Og. Citizen of W	nat Country?	
	s 23s	rai	7003 Martha Avenue			21219		United		
21215-0036	72 hours after death with the Maryland "naturel", or Items 23a or 28a-1 show collest Examiner must be mutified at	by Funeral Directo	Arme 1 ☐ Never Married 2 ☑ Married 1 ☑ 1	Decedent Ever in U.S. of Forces? fes 2 No s, Give or Dates: 1959-63	3. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ★ No		o Rican, etc.)		- American Indian, , White, etc. White	
2-0	72 ho	Completed	15. Decedent's Education (Specify only highest grade comple	16a. De	cedent's Usual Occu	pation	-tri	16b. Kind of Bus		
21	- 3	nple		ge (1-4or 5+)	ive kind of work done e. DO NOT use retir	ed)	rking			
	filed wi Hygien sther th		12 Years	Me	chanical				Industry	
Maryland	2 should be filed withir and Mental Hygiene. Is marked other then aumatic event, the Ma	Be	17. Father's Name (First, Middle, Last)	G			me (First, Middle, M			
Ë	should ind Men i marke	2	Elmer L. Rudacille, 19a. Informant's Name/Relationship (Type, Print)		ailing Address (Stree		lizabeth			
<u>s</u>	d 2 s Ith an 27 is		Mrs. Shirley F. Rud		3 Martha		dgemere,			
5	ges 1 and 2 should be filed within to filed within to file Health and Mental Hygiene. If Item 27 is marked other then or other traumatic event, the Me		20a. Method of Disposition	20b. Place of Di	sposition (Name of		Date	20c. Location - C	ity or Town, State	
ê E	Pages ent of nt: If It ry or o		1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal f 4 ☐ Donation 5 ☐ Other (Specify)	rom State '	orematory or other plants	1	1/4/2005	Baltim	ore, Maryl	and
Baltimore,	permit. Page Department of Important: If eny injury or		21. Signature of Funeral Service Licensee	1 00	22. Name and Addr Duda-Ruck 7922 Wise	ess of Facility Funeral		oundalk,	Inc.	
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P.O. Box 6	that the death certifice led by the attending ph detached for use as the	Physician/Me	in the past 12 months?		3 □Ectopic pregnand 5 □ Other (specify) _	ey .		23d. Date Mont	,	ear
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai	(Check only 2 Medical Examiner: On t	o the best of my knowledge, de the basis of examination and/or manner stated.	eath occurred at the t r investigation, in my	ime, date and place opinion, death occu	, and due to the ca rred at the time, da	use(s) and manr te and place, an	ner as stated. d due to the cause(s)	
	To t To t	Σ	29b. Signature and title of certifier			se number	29		Month, Day, Year)	
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1	ピン		30. Name and address of person who completed Dr. Donnegan GBMC 1	West Suite Ba	ltimore,					
	Sta Registr			2. Registrar's Signature	1. Spark	W. Comments of the Comment of the Co				

		1 - For State Registrar	State of Maryland / De	epartment of Health and Certificate of Death	Mental Hygie	
Physic /Med		1. Decedent's Name (First, Middle, Last	Ruffin			Day Year 2 3. Time of Death
Exami - Funeral Director	ner	4a. Facility Name (If not institution, give University of M 5. Social Security Number 231-42-938715	street and number) Arifland Medical Cent X 7. Age (In yrs. last birthd) Yrs	ay) If Under 1 Year If Under 24 Hrs	8. Date of Birth	4c. County of Death N/A Bighplace (State or Fore) Governity)
the Maryland 28a-f show	ector	Usual Residence of Decedent 10a. State 10b. County 10b. Street and Number	Bal-	Location Himore 101, Zip Code	100	10d. Inside City Limi
5-UU36 72 hours after death with the Maryland naturel', or Items 23s or 28s-f show after Executed to mat be notified at	d by Funeral Director	1354-Pentri 11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. 12. Was Decedent Ever in U.S. 1 — Yes 2 No If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puel 1 Yes 25 So Specify:		14. Race - American Indian, Black, White, etc. Specify: Black
STZIS- Sed within 72 rgiene.	Completed	15. Decedent's Edu (Specify only highest grad Elementary Secondary (0-12)	le completed) (G	icedent's Usual Occupation ive kind of work done during most of wo is DO NOT use retired. The Chy Fire Fig. 18 Mother's Na.	orking 16b	Kind of Business/Industry The Fighter (as Sumana)
B is g is	To Be	Herbert Ru	UFFIN 19h M	ailing Addr 45 Street and Number or R	ie Ha	y or Town, State, Zip Code)
ore, es 1 an of Heal of Item 2		20a. Method of Disposition	200. Place of Discembery, Commoval from State	Sposition (Name of prematory or other place)	Date 19/05 D	Location - City or Town, State
DEMIT PAGES 1: Department of He Important: If Iten any injury or oth		4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licens	n MO1363	Ray Sout and lucentum 2 Jame and Address of Fability 4905 John 1	tune to	rodnot virgini meral Services MD 21212
Cate be executed cate be executed physician and physician and the buriar-transit	dical Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Hemorhage Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	of Aurtic	Root	Approximate Interval Between Onset and Death
the death certification of the attending processes as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
hat bd b	by	Part II. Other significant conditions con	ntributing to death but not resulting in the	e underlying cause given in Part I.		o use contribute to the cause of death? 2 XNo 3 □ Probably 4 □Unknow
The fav ate has page 2	Completed	25. Was case referred to medical		- 1/63	24a. Was an autopsy penformed:	
Physician: rthis certifica	To Be	examiner?	lospital: 1	Other	ath Check only one forms 5 Residence	6 Other (Greek)
To the Hospitel or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directors.	atlon: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at	28d. Describe how in	
Itel or Atterns after de rai Directe led in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)		City or Town, Sta	
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical	one)	sician: To the best of my knowledge, de ner: On the basis of examination and/or and manner stated.	eath occurred at the time, date and plane investigation, in my opinion, death occu	and dua to the exuser arred at the time, date a	(e) and manner as statud; and place, and due to the cause(s)
Mith To T	Σ	29b. Signature and title of certifier	Dunton	29c. License number Au 417643 (**D/3		Date signed (Month, Day, Year)
		30. Name an address of pers the	pleted cause of leath (Item 23a) (Typ	AU417683(D1) OSter) St. 3	altimore m	77 21236
Sta Regist		31. Date filed (Month, Day, Year)	32 Registrar's Signature		·-	

	For	State of Maryland / Department of Health and
1-	For State Begistrar	Certificate of Death

1. Decedent's Name (First, Middle, Last)

3. Time of Death

Reg. No.

Day

Year

2. Date of Death

	Fune Direc
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If term 27 is marked other then "naturat; or iteme 23e or 28e-1 show any injury or other grammeric agent."
>	Physici /Medic Examir

Physician Aaron Stowers 28, 2005 12:40 P. Oct. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death miner Baltimore Woodlawn 7120 Bexhill Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
June 30,1944 Georgia 5. Social Security Number 7. Age (In yrs. last birthday) ral Months Days Hours Min. 1 □ M 2 □ F 216-42-8176 Yrs. tor Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits Woodlawn Baltimore 1 ☐ Yes 🕏 ☐ No Maryland 101. Zip Code 21 2 4 4 10e. Street and Number 10g. Citizen of What Country? 7120 Bexhill Road USA Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Specify Black 1 Never Married 2 Married 1 ☐ Yes 2√ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Finger Print Specialist Federal Government Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Marion Stowers Frances Patterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheila Stowers/Wife 7120 Bexhill Road Baltimore, Maryland 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 11/40/05 X□ Burial 2 □ Cremation 3 □ Removal from State Garrison Forest Vet.Cem Owings Mills, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home any ir 5240 Reisterstown Rd Baltimore, Md 21215 23a art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -112k enliver WELKS disease or condition resulting in death) al Due to (or as a consequence of): Liver metastazes ier ears ancal olon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): ng physicien and as the burial-transit The law requires that the death certificate be executed Exami that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical attending I IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 1 ☐ Yes 2 ☐ Wo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 1 ☐ Yes 2 ☐ No 2 No 1 Yes Division of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ✓ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No ٩ this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Attending 1 Natural 5 Pending death. I Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after des To the Funerel Director completely filled in by th 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 0032105 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUKILDO S 2401 DIDOLKAG OWI Belvedere 31. Date filed (Month, Day, Year) 32. Registrar's Signature State House It Speck MOK 0 7 Registrar 2005

			For State Registrar	State of M	aryland /	Depa <i>Cer</i>	artment of rtificate c	f Health of Deat	n and Menta th	al Hygier Reg.	- 000	35795
	Physicia		1. Decedent's Name (First, Middle, I	.ast)						ate of Death onth	Day Year	3. Time of Death
	Physicia /Medic			. SPARRO	MC						3, 2005	8:30A M
	Examin	ėr	4a. Facility Name (If not institution, g				4b. City, Town			ITY	4c. County of Dea	ın
	Funeral			Sex 7. Ag	e (In yrs. last	birthday)	If Under 1 Ye	ar If Und	der 24 Hrs. g Da	ate of Birth lonth, Day, Ye	Q Rir	thplace (State or Foreign
	Director		214-38-0012	1□M 202F	67	Yrs.	Months Da	ys Hour	01	1/12/1	938 MZ	ARYLAND
	and ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation					10d. Inside City Limits
	Mary F sho	tor	MD N/A			BAI	TIMOR	E CIT	ľY			XXYes 2 □ No
	th the	lrec	10e. Street and Number		J		10f. Zip Cod			10g.	Citizen of What C	ountry?
	ath wi	ral	4301 GROVELA			1.0.		215	0::10/0 // 1		USA	-dona ladia a
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Heath and Mental Hygiene. Item 27 is marked other then "neturel", or Items 23e or 28e-f show other treumatic event, the Madical Examilier restable reciliated at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 □ Yes 21 If Yes, Give Year or Dates:	No No		Was Decedent If Yes, specify 0 1 ☐ Yes 2 [X]		Origin? (Specify Y ican, Puerto Rican, cify:	es or No- , etc.)	14. Race - Am Black, Whi	te, etc.
2	72 ho netur	Completed	15. Decedent's (Specify only highest)	Education grade completed)	10	6a. Deced	dent's Usual Oc kind of work do	cupation ne during n	nost of working	16b	. Kind of Business	/Industry
12	within the	mple	Elementary/Secondary (0-12)	College (1-4or	5+)		DO NOT use re DUSEWI				OMESTI	7
	filed v Hygie other t	e Co	12TH 17. Father's Name (First, Middle, La	st)	l	- 110	JOSEWI		other's Name (First			
<u>a</u>	Mental Mental arked c	To Be	CHARLES BUTI	ER				SZ	ARA WATI	KINS		
Maryland	2 should and Men is marke eumatic		19a. Informant's Name/Relationship		1				mber or Rural Roul		•	
	l and lealth		SHEILA SPARRO	W/DAUGHTE			I GROV esition (Name of		D AVE.,		LMORE, L Location - City or	AD 21215
Baltimore,	permit. Pages 1 ar Department of Hea Importent: If item any injury or other		1 Surial 2 ☐ Cremation 3 1 Donation 5 ☐ Other (Spe	☐Removal from State cify)	MD ^{cerpe} CROW	ETE INSV	RANS C	EM.	11/09/0		ROWNSVII	
Ball	Departing Departing Important in any in any in any in		21. Signature of Taneral Service Lie	censee A. A.	SUM		2. Name and Ad		110 1101			OME 21207
			23a. Par Ener the disease, or co	emplications that cause	d the death. D	Do not ent	er the mode of	dying, such	Y HEIGH'. as cardiac or resp	I'S AVE piratory arrest,	5., BAL'.	Approximate Interval Between
	Priysician		shock, or beart failure. List or Immediate Cause (Final disease condition			vac-age co-	- مدد					Onset and Death
	/Medical		resulting in death)		a consequen		الدون	SENT				Urknews
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rds, P	Se Pe	by	Part II. Other significant condition	s contributing to death t	out not resultin	g in the u	nderlying cause	given in Pa	art I. 2		co use contribute t	o the cause of death?
l Records,	The ate h page	Completed								4a. Was an autopsy performed	prior to	utopsy findings available completion of cause of s 2 No
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othon	lace of Death (Che			
of	di S	1.	1 Yes 2 No	28a. Date of Inj	ent 2 ER/	Outpatier b. Time o		4 10	Nursing Home 5	5 🗌 Residence Describe how i		ecify)
On	Attending r death.	tlon	1 Natural 5 Pending 2 Accident investiga	(Month, Da	ay Year)	Injury		njury at Work? 1 🗌 Yes 2				
Division	or Attenafter deatl	Certification:	3 Suicide 6 Could no 4 Homicide determin	ed 286. Place of In	jury - At home tc. (Specify)	, farm, sti	reet, factory, off	ice	28f. Lc	ocation (Street lity or Town, St	t and Number or R	ural Route Number,
Ö	itel or A	Cer		Januari g, J								
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical		Physician: To the best saminer: On the basis of and manner s	of examination							
	To the I within 2. To the I complet	Med	29b. Signature and title of cortifier	and mannor s			29c. Lic	ense numb	per	29d.	Date signed (Mon	th, Day, Year)
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/			30. Name and address of person w						72 -	D	m ^ 2	1215
	Sta	ite	31. Date filed (Month, Day, Year)	32. Regist	rar's Signatur	3. /	pooled	المالة	1	Dalt	110 2	N 60 1 0
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15 1 - For Stata Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Joginder Singh 2005 November 9:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Prince George's Laurel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**7** M 2□ F Days Yrs. Director 60 March 25 NA India Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show traumatic avent, the Madical Examiner must be notified at 1 ☐ Yes 2 X No Directo Sheikn Sarai, New Delhi, India NA NA 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5 ferms 23a 110017 3B SFS Category I India 2 should be filed within 72 hours after death and Mental Hygiene. Completed by Funeral Phase I 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Asian Indian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Assistant Commissioner IRS Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Uttam Kaur Kartar Singh 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: if itam 27 is iury or other trau Meharban Singh/nephew 15533 Thompson Road, Silver Spring, MD 20905 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or once. 4 □ Donation 5 □ Other (Specify) West Arundel Crematory 11/6/2005 Odenton, MD 22. Name and Address of Facility Donaldson Funeral Home & 21. Signature of Funeral Service Licensee M01427 Crematory, P.A. 1411 Annapolis Rd. Odenton, MD Domenico amodeo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Acute Myocardial Infarction 2 weeks disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence of). Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No signed by the atte Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hypoxic Encephalopathy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an has 2 X No certificate 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 🔀 No Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After or Attanding 1 XNatural Injury 5 Pending after death. death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ٥

Registrar
DHMH 17 Rev 1/2001

State

D23181

#T-1 Laurel, MD

November 5, 2005

M

704 Gorman Ave.,

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R.G. Bhojraj, MD

NOV 0 7 2005

31. Date filed (Month, Day, Year)

			State of Maryland / Department of Health and Certificate of Death	Mental Hy	giene	5 35797
	,		Decedent's Name (First, Middle, Lest)	2. Date of De	eath	3. Time of Death
	Physici /Medio		Steven M. Sherry, Sr	Month	3 2	005 2112
)	Examir		4a. Fesility Name (If not institution, give street and number) 4b. City, Town, or	1	mon'	of Death
			5 Social Security Number 6 Sex 7 Age (In vis. last hithdray) If Under 1 Year If Under 24 Hr.	Burk	-	4
	Funeral		Months Days Hours Min	. (Month, Da	th ay, Year)	9. Birthplace (State or Foreign Country)
	Director		216-68-9896 48 175. Usual Residence of Decedent	Dec. /	, 1930 N	Vashington, DC
	yland		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Marie 1	ţċ	MD Anne Arundel Gambrills			1 ☐ Yes 2 ŽŽNo
	or 28	- Jie	10e. Street and Number 10f. Zip Code		10g. Citizen of W	/het Country?
	ath w	Funeral Director	1008 Springhill Way 21054		U.S.A	
	er de	n n	11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (3 If Yes, specify Cuban, Mexican, Puel	Specify Yes or No rto Rican, etc.)	b- 14. Race Black	e - American Indian, k, White, etc.
20	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28e-f show int, the Medical Examiner must be notified at	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give 1 □ Yes 2 □ No Specify: 3 □ Widowed 4 □ □ Norced Year or Dates: 1974		Specify:	
ခု	tural E	B	15. Decedent's Education 16a. Decedent's Usual Occupetion		16b. Kind of Bu	white siness/Industry
212	Par Par A	Completed	(Specify only highest grede completed) (Give kind of work done during most of wo life. DO NOT use retired) (Give kind of work done during most of wo life. DO NOT use retired)	orking		ŕ
7	giene grene graft	ĕ	10th Carpet Mechanic		Carpet	Installation
Maryland 21215-0020	tai H	Be		ime (First, Middle	, Maiden Surname	θ)
₹	should be food Mentail Bararked of Immetic even	2	John Joseph Sherry Charlo			rdan
Mai	C1 0 12 80	9	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R			
رة _	1 and Health sm 27 ther tr		Charlotte L. Sherry/mother 1008 Springhill Way, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Gambrill Date		. 054 City or Town, State
ō	Peges nent of h int: if ite		1 Laburial 2 Li Cremation 3 Li Hemoval from State	9 Nov.		
Baltimore,	permit. P Departme importani any injury once.	179	4 □ Donation 5 □ Other (Specify) Ft. Lincoln Cemetery 21. Signature of Funeral Service Licensee 22. Name end Address of Facility	2005	Brentwoo	oa, MD
ä	permi Depar impol any ir	(1)	Donaldson Funeral		•	-
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	Odenton ac or respiratory e	م MD ZII rrest,	Approximate Interval Between
1	Physician	F 184	shock, or heart failure. List only one cause on each line.			Interval Between Onset end Death
1	/Medical		Immediate Ceuse (Final disease or condition Acute Cardiac Ar	pryth	MIF	munites
	Examiner	L	Immediate Ceuse (Final disease or condition resulting in death) e. Acute Cardiac Ar Due to (or as e consequence of): Arteriosalerotic He	-		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
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	tificate be executed g physician and as the bunal-transit	Exar	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of):			
68760,	e be (siciar	edical	Cause (Disease or injury c			
			resulting in deeth) Last			
Вох	th cer tendir rr use	Physiclan/N	1 d.			
<u>.</u>	e dea he att	Sicl	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did	tobacco use con	tribute to the cause of death?
<u>.</u>	Attending Physician: The law requires that the death cert at describerable. After this certificate has been signed by the attendin by the funeral director, page 2 should be detached for use	£		10	Yes 2□ No	3 ☐ Probabiy 4 Denknown
ds,	signe d be o	d b		24a Was	an autopsy	24b. Were autopsy findings
Ď	requ been shoul	ete		perfo	rmed?	available prior to completion of cause
Ä	has ge 2:	Completed			- A.	of deeth?
Vital Records, P.O.	n: Th ficate or, pa		25. Was case referred to medical 26. Place of De	ath (Check only o		1 ☐ Yes 2 ☐ No
>	/sicials cert	To Be	examiner?	Home 5 ☐ Resi		r (Specify)
ō	g Phy ter thi		27. Manner of Deeth 1 Manuary S ☐ Pending 28e. Date of Injury (Month, Day Year) 28b. Time of Injury at (Month, Day Year) 28c. Injury at (Month, Day Year)	1	how injury occurre	
<u> </u>	uttendin death. ctor: Aft y the fu	atlc	2 Accident investigation M 1 ☐ Yes 2 ☐ No			
Division of	or Atter de direct	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (. City or To		er or Rurel Route Number,
	pitai o	Se	29a. Certifier 1☐ Certifying Physicien: To the best of my knowledge, death occurred at the time, date and plec			
	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours eiter death cart. To the Lunarai Directors this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use.	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and plect (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plect (Check only one)	urred at the time,	date and place, a	nd due to the cause(s)
	To the Hospital or Att within 24 hours efter of To the Funeral Direct completely filled in by	Me	29b. Signature and title of certifier Deputy 29c. License number			(Month, Day, Year)
			William My mos Doods	004		4/5
1		ĺ	Milling Jones, und Doods 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) Milling P. Jones, und 695 Amer		110	3
			31. Date filed (Month, Day, Year) 32. Registrer's Signature	" LC M	010	77
	Sta Registr		NOV 0 7 2005 Peaces A April			

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 05 35798 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** October 25, 2005 1:45 A Regina A. Schatz /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie Mariner Health and Rehab Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) Funeral Days 1 □ M 2 X F Director 218–18–9155 82 May 5, Maryland Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-1 show other traumatic event, the Medical Examiner must be notified at Maryland Glen Burnie 1 ☐ Yes 2 No Anne Arundel Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 295 Scotts Glen 21061 or Itams 23a United States death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status be filed within 72 hours after de ntal Hyglene. d othar than "natural", or Itami 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Š 3 X Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fil ment of Health and Mental H tant: If itam 27 Is marked otl William Downey Regina Allers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bevery Yates - daughter 295 Scotts Glen, Glen Burnie, Maryland 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Meadowridge Cemetery 10/28/05 Elkridge, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature & Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 1229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician congestive heart failure /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last dementia Due to (or as a consequence of): Examine be executed the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, attending physician Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown for Year Month Day 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe pneumonia 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2X No 1 Yes 2**X** No Division of Vital Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 2 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t il or Attanding F safter death. I Diractor: After Certification: 1 XNatural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To tha Funaral C 29a. Certifier 1 💢 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 1201 D55506 October 31, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fer Eren MD, 8109 Ritchie Highway, Pasadena, Maryland 21122 31. Date liled (Month, Par/Yer) 7 2005 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiepen 15 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 4, Russell Stanley Smith November 4:15 P 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Timonium Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12/29/1921 5. Social Security Number 7. Age (In vrs. last birthday) Funeral Birthplace (State or Foreign Country) PA 1 ★M 2 ☐ F 176-16-5804 Director Usual Residence of Decedent the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State 28e-f ehow other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2X No Director Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9101 Deviation Road 21 2 3 6 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes. Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene.

Is marked other than "naturel", or iter 1 ☐ Never Married 2 Married 1 Yes 2 No Specify White If Yes, Give Year or Dates: Specify. Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) EMBER Electronics Engineer Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George E. Smith Jennifer Reifschneider 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann C. Smith / spouse Health Item 27 9101 Deviation Road, Perry Hall, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Importent: If It eny Injury or o ₹ 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Dogation 5 ☐ Other (Specify) Hilltop Svc. Corp.: 11/10/05 Towson, Marvland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Foneral Service Len 1050 York Road, Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER **Physician** -UNG disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, beauing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of attending physicien and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) certificate has been signed I rector, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1□ Yes 2 No 1 Tyes 25. Was case referred to medical Be 26. Place of Death Check only one examiner' Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA 1 ☐ Yes 2 No After this funeral dir 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a 29a. Certifier Microtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D43725 11/4/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY 10

Registrar DHMH 17 Rev 1/2001 TIMONIUM, MD.

M.D.

3 Registrar's Signature

MAHMOOD,

31. Date filed (Month, Day, Year)

MOV 0 7 2005

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records, P.O.

31. Date liled (Month, Day, Year)

NOV 0 7 2005

32. Registrar's Signature

Certificate of Death

1 - For State Registrar

2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** SNYDER MERRILL Nov 02 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BAUTIMORE, MD SINA HOSPITA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth MAY 25,1919 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1₩ 2□F 86 185-14-3056 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 28a-f ehow itam 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be inclined at Director BALTIMORE MD N/A 10e. Street and Number 10f. Zip Code 7013 WALLIS AVENUE 21215 12. Was Decedent Ever in U.S. Armed Forces? 1 1X Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7;
Department of Health and Mental Hyglene.
Important: If itan 27 is marked other then "na any injury or other traumatic event, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) MICROBIOLOGIST 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SNYDER GUSSIE MILTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7013 WALLIS AVENUE - BALTIMORE, MD 21215 MURIEL SNYDER / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State ARLINGTON CHIZUK AMUNO 11/04/2005 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Se 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician METASTANK SMALL COLL CANCEL /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner been signed by the attending physician and should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by Hyperter's10 2 HYPERUPIDEMIA 24a. Was an page 2 autopsy performed 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient ٩ filled in by the funeral dir 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation after death. М 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours at To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29c. License number 29b. Signature and title of certifier RES-BOO completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

35801 Reg. No. 3. Time of Death Year 04:45 AM 2005 4c. County of Death N/A Birthplace (State or Foreign Country) PA 10d. Inside City Limits 1 X Yes 2 □ No 10g. Citizen of What Country? USA 14. Race - American Indian, Black White etc. WHITE Specify: 16b. Kind of Business/Industry MEDICAL SCIENCE JANOWITZ 20c. Location - City or Town, State BALTIMORE, MD Approximate Interval Between Onset and Death 23d. Date of delivery 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) NOV 02, 2005 W. BELVEDERE AVE, BANDMONE, MD 21215

State Registrar

2401

32. Registrar's Signature

J. A. YO40 MD 31. Date filed (Month, Day, Year)

NOV 0 7 2005

		-	1 - For State of Maryland / Dep	artment of Health and Mental I rtificate of Death	Hygien 2005 35802
	. Physicia	47	Decedent's Name (First, Middle, Last)	2. Date of Month	Day Year
-	/Medic	- 51	KENNETH THOMAS, JR.	OCTO	DBER 31, 2005 3:51P. M
-	Examin	er	4a. Facility Name (If not institution, give street and number)	BALTIMORE	N/A
7	Funeral		SINAI HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	if Linder 1 Year If Linder 24 Hrs 9 Date of	Birth 9. Birthplace (State or Foreign Country)
184	Director		213-84-5131 X M 2 F 32 Yrs.	Mortilis Days Hours Min. 07/	Day, Year) Country MARYLAND
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits
	Mary -f sho	tor	MD N/A	BALTIMORE CITY	1X Yes 2 ☐ No
	th the	irec	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	ath wi	Funeral Director	4310 MAINE AVENUE	21207	USA
	or Items	une	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 ▼XNever Married 2 Married 1 ─ Yes 2 ▼ No	Was Decedent of Hispanic Origin? (Specify Yes o If Yes, specify Cuban, Mexican, Puerto Rican, etc.	
336	urs aft	by F	3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 ☐XNo Specify:	Specify: BLACK
21215-0036	72 hours after death with the Maryland naturel', or liems 23a or 28a-f show liest Ezard act mun to multisd at	eted	(Specify only highest grade completed) (Giv	edent's Usual Occupation a kind of work done during most of working	16b. Kind of Business/Industry
121	within ene. then "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) RUCK DRIVER	TRANSPORTATION
d 2	be filed within 72 hours after death with the Marylan ital Hyglene. Id other than "naturel", or items 23a or 28a-f show event. The Maritsal Examination must be collined at	ပိ	10TH 17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mid	
Maryland	lid be lental rked o	To Be	KENNETH W. THOMAS, SR.	LORRETTA	HAZEL
lary	s 1 and 2 should f Health and Men item 27 is marke other traumatic			ing Address (Street and Number or Rural Route No	
	1 and 3 Health tem 27 other tr	9	KENNETH W. THOMAS, SR/FATHER	4600 MAINE AVENUE,	
Baltimore,			1 M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) **Cemetery, circles KING MI	ematory or other place) EM. PARK 11/05/05	
Balt	permit. Page Department of Importent: If any injury or once.		// when / Chara	12. Name and Address of Facility HOWELL 1600 LIBERTY HEIGHTS	AVE., BALTIMORE, MD
	A		23a. Pen Enter the disease, or complications that caused the crath. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or respirato	ry arrest, Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease of condition resulting in death)	1 Woundot He	od .
7. No.	Examiner		Due to (or as a consequence of):		
	P #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
	ecuted and trans	Examiner	Cause (Disease or injury that initiated events c		
60,	cate be executed physicien and the burial-transit	cal E	Due to (or as a consequence or).		
68760,	ificate g phys		d		
Box	death certificate be executed te attending physicien and od for use as the burial-transit	an/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy	23d. Date of delivery Month Day Year
E	at the dea by the at- nached fo	Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown 1 Ves 2 No 9 Unknown	Other (specify)	— Jay Feat
<u>α</u>	ge ge g	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. t	Did tobacco use contribute to the cause of death?
rds,	w requires been sign should be				I Yes 2 No 3 Probably 4 Unknown
Record	law requ as been 2 shoul	Completed			Mas an 24b. Were autopsy findings available prior to completion of cause of
	The Late ha	Con		- 9 ⁴	performed? death? es 2 □ No 12 ves 2 □ No
Vital	Physician: this certificantal director, it	Be	25. Was case referred to medical examiner?	26. Place of Death (Check of Death) Other:	
of		. To	27. Manner of Death 28a. Date of Injury 28b. Time	STIL 3 DOX 4 Norsing Home 3 1	Residence 6 Other (Specify) ibe how injury occurred
ion	Attending I r death. ector: After by the funer	atior	1 Natural 5 Pending (Month, DayYear) Injury 2 Accident investigation	9 M 1 Yes 2/000 SC	eljets hit
Division	or Attende:	Certification:	3 Suicide 4 Could not be determined 4 Could not be determined building, etc. (Specify)		on (Street and Number or Rural Route Number, r Town, State)
	urs aff urs aff erei Di		STE	7 4(50)	Maine the 21207
	To the Hospitel or Attention 24 hours after de To the Funerel Directo completely filled in by the	Medical	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, dei (Check only one) 29a. Certifier 1	nvestigation, in my opinion, death occurred at the ti	the cause(s) and manner as stated. me, date and place, and due to the cause(s)
	To the Within To the	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			(Corhesso)	O.C.M.E.	NOVEMBER 1,2005
			30 Name and address of person who completed cause of death (Item 23a) (Type	111 PENN STREET BALTII	MORE MARYLAND 21201
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	les .	
*	Regist	rair	NOV 0 7 2005 Marie 15 19		

			1 - For State of I		artment of Health and leath	Mental Hygie	2000	35803
ı	Physici		Decedent's Name (First, Middle, Last) RAY TURNER			2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and numb	er)	4b. City, Town, or Location of Death		4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 7. 1 M 2 □ F	Age (In yrs. last birthday, 90 Yrs.			9. Birth	place (State or Foreign ntry) CAROLINA
	inyland thow		Usual Residence of Decedent	10c. City, Town or L				10d. Inside City Limits
	r 28a-1 s	Director	10e. Street and Number	BALT	IMORE CITY 10f. Zip Code	10g.	. Citizen of What Cou	1 XYes 2 No ntry?
	238 o		3501 HOWARD PARK AVE	., APT. #:	229 21207		USA	
36	d within 72 hours after death with the Maryland Jene. Ir than "natural", or items 23a or 28a-1 show The Medical Esanthar must be rediffed at	by Funeral	11. Marital Status 1 Never Married	es? X ^{No}	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ▼ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White, Specify: RT	
9-9	72 hour naturai dical Ex	ted b	15. Decedent's Education	16a. Dece	edent's Usual Occupation	161	o. Kind of Business/Ir	
21215-0036	ed within 7: glene. er than "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) 6TH College (1-4	or 5+)	e kind of work done during most of wor DO NOT use retired) STODIAN	king E	BALTIMORE SYSTEM	
Maryland	should be filed nd Mental Hygi marked other umatic event, "	To Be (17. Father's Name (First, Middle, Last) JOHN TURNER		18. Mother's Nar	ne (First, Middle, Mai	den Sumame)	
	1 and 2 sh Health and em 27 ie m		19a. Informant's Name/Relationship (Type, Print) RAYMOND TURNER / SON 20a. Method of Disposition	2702 20b. Place of Disp	ing Address (Street and Number or Ru 2 GARRISON BLVL osition (Name of	BALTI		21216
altimore,	Pages ment of ant: if it ury or o		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	110	matory or other place) NN CEMETERY 11/	12/05 E	BALTIMORE	CO., MD
Balt	permit. Page Department of important: If any injury or once.		21. Signatur Fyheral Service Licensee	- X /	2. Name and Address of Facility $ m~H$ $ m^{1}4600~LIBERTY~HE$			ME 21207 IMORE, MD
	Physician		23a. Faul Enter the disease, or complications that au single, or heart failure. List only one cause on eac Immediate Cause (Final disease or condition		ater the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		61	as a gonsequence of):	····		:	60min
	be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c	as a consequence of):				
8760,	icate be executed physician and s the burial-transit	dicai Ex	resulting in death) Last Due to (or	as a consequence of):				
.O. Box 6	that the death certific led by the attending p detached for use as	Physician/Med		n 2 □ Fetal death 3(It at time of death 5(□Ectopic pregnancy □ Other (specify)		23d. Date of deliv Month	ery Day Year
Д.	luires that n signed by	by	Part II. Other significant conditions contributing to deat	the pro	underlying cause given in Part I.		co use contribute to t	/
Vital Records,	The law requires that ate has been signed b page 2 should be deta	Completed	bony metastatic	disea	se	24a. Was an autopsy performed	death?	opsy findings available impletion of cause of
/ita	Physician: This certificated director, p	Be	25. Was case referred to medical example:	,		th Check on one		
of	Phys r this rat dir	ion: To	Torratoral 3 di Giding		of 28c. Injury at Work?	ome 5 Residence 28d. Describe how		(y)
Division	Atten or deat ector: by the	ertification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of building	Injury - At home, farm, st , etc. (Specify)		28f. Location (Stree City or Town, S	t and Number or Rura itate)	al Route Number,
	n Hospitai or 124 hours afte n Funeral Dir netely filled in	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the basis and manner and man	s of examination and/or in	th occurred at the time, date and place nvestigation, in my opinion, death occu	, and due to the caus rred at the time, date	e(s) and manner as s and place, and due t	stated. o the cause(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month,	Day, Year)
)			ranij vinau-		D0021730	1 (Jav 6	2005
<			30. Name and address of person who completed cause	of death (Item 23a) (Type	W. Beliedera	110-	RAH .	M 01216
Ì	Sta		31. Date filed (Month, Day, Year) 32, Reg	istrar's Signature	assist .	1704	120,1	111 21/13
	Registi	rar	NOV 0 7 2005	poster son from				

State of Maryland / Department of Health and Mental Hygiere 0 05 35804 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** November 2005 9:20 Tripoda Margaret /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 207 Bayside Drive Dundalk Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 30, 1 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗙 F 1920 Pennsylvania **Director** 220-30-2022 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Md. Baltimore Dundalk Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 207 Bayside Drive United States permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If itam 27 Is marked other than "natural", or Items 23a any injury or other traumatic event, the Medical Examinat must once. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No ģ Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry ring most of working Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Public Health Nurse Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas Nevin Atherton Ella Mae Butts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 21030 (Friend) 1016 Saxon Hill Drive Cockeysville, MD William J. Gering 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State Lincoln Cemetery 11/5/2005 Chambersburg, PA * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Mouth Cancer Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) Ö 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 No r: After this certifica e funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death

1. Natural

2. Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 11-2-2005 54 Scott Adams Road Cockeys Ville MD 21030 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIMON, MA 31. Date filed (Month, Day, Year Registrar

				For State Registrar	State of N	Marylar		artment of H	lealth and Death		giepe Reg. No.	005	35805
	₹.	Physici	an	1. Decedent's Name (First, Middle,	Last)					2. Date of De	ath Day	Year	3. Time of Death
		/Medie	cal	Basilio 4a. Facility Name (If not institution,	Vasquez	r)		4h City Town	or Location of Deat	Kenb		2005 County of Death	1:20 PM
•		Examir	ıer	^	hington Me		Center	0 0	Burnie		0	ne Ali	andel
		Funeral		5. Social Security Number	6. Sex 7. A 1 X M 2 ☐ F	ge (In yrs.	last birthday)	If Under 1 Year Months Days			h		place (State or Foreign
		Director		580-96-1868 Usual Residence of Decedent	TOM 201	61	Yrs.			Aug. 21	, 19	44 Puert	
		yland how		10a. State 10b. County		10c. Ci	ty, Town or La	cation			-		10d. Inside City Limits
		8s-fs	Director		Arundel		Ode	nton					1. Yes 2 No
		with the	Dire	10e. Street and Number				10f. Zip Code	01110			en of What Cou	
		death ms 23	Funeral	1894 Bragg Way	12. Was Deceder	nt Ever in U	J.S. 13.		21113 Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No		ited Sta 4. Race - Americ	can Indian,
	9	or Ite	Fur	1 Never Married 2 Marne	Armed Forces d 1 Yes 2 If Yes, Give			f Yes, specify Cubi 1 XI Yes 2 □ No			1	Black, White, Specify:	etc.
B	5-0036	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "natural", or Items 23e or 28s-f show event, the Madical Examinar must be notified at	ed by	3 ☐ Widowed 4 🙀 Divorced	Year or Dates	: 				rto Rica		WI	nite
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QUE	Ž	d 2 should th and Mer ? Is marke traumatic	မှ	Lorenzo 19a. Informant's Name/Relationshi	Vasquez		19b. Mailir	ng Address (Street	Mari and Number or Ru		DeJe:		Codel
B		1 and 2 s Health ar em 27 is ther trau		Lissette Garcia				Bragg Wa		ton, Mar			, 0000,
AS	Ba timore,	S to == 0		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation	3 Removed from State		Place of Dispo	sition (Name of natory or other plan	ce)	Date	20c. Loc	ation - City or To	own, State
4	ţį	permit. Pages Dependent of I Important: if Its any injury or o		4 Donation 5 Other (Sp.	ecify)				ory 11/				Maryland
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	I			23a. Parti Enter the disease, or o shock, or heart failure. List o	omplications that cause nly one cause on each	ed the dear line.	th. Do not ent	er the mode of dyir	ng, such as cardia	c or respiratory ar	rest,		Approximate Interval Between
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			ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	is a consec	tuence of):	010313				1	10/11/13
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	9	fficate g physi	edical		d								
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	O. III	e deal the att	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant 9□Unknown	at time of c		Other (specify)	y 			Month	Day Year
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	Ö	nding lath. r: After e funer	atior	1 Watural 5 Pending 2 Accident Investiga		Jay Year)	Injury		rk? Yes 2∐No		,		
	Division of Vital Records,	after de after de l'Directo	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place of li building,	njury - At h etc. <i>(Speci</i>	ome, farm, str	eet, factory, office		28f. Location (S City or Tou	Street and m, State)	Number or Rura	il Route Number,
		To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical C	29a. Certifier 1/S4Certifying (Check only one) 2 Medical E	Physicien: To the bes xaminer: On the basis and manner:	of examina	owledge, death ation and/or inv	occurred at the tir restigation, in my o	me, date and place opinion, death occu	e, and due to the curred at the time,	cause(s) a date and p	and manner as si place, and due to	tated. the cause(s)
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10	1			30. Name and address of person w	ho completed cause of		п 23а) (Туре,	Print)	Da 6-1	. p		1 1111-	0.01/
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Jocslyn Velez 05-07276 crn

	1. Decedent's N	ame (First, Middl	le, Last)			_		2	ental Hyg 49 -05 tas 2. Date of Death	1		3. Time of Death
hysician /Medical	Joscel	n Renae							October	28		12:18 P
Examiner		e (if not institution es Hospi	n, give street and numbe Ltal	or)	4b.	City, Town, o Baltin		of Death		4c. Co	ounty of Death N/A	
uneral rector	5. Social Securit	y Number LINK	6. Sex 7. A 1 ☐ M 2 ☑ F	Age (In yrs. last b	Yrs Mo	Inder 1 Year	If Under Hours	Min.	B. Date of Birth (Month, Day,	Year)	Cour	2' _
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or other	20a. Method of I		3 Removal from Stat		of Disposition	(Name of or other place	ce)	Dat	10 2	Oc. Locat	tion - City or To	own, State
any injury or		on 5 Other (S		Loudor	n Park		,	l1-5-0			more, l	
Buc	21. Signature of	Funeral Service	Licensee		11				oard F			me, Inc
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State of Maryland / Department of Health and Mental Hygiene 05 35807 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Beverly Cecelia Wilson 31, /Medical October 2005 10:05 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral 6 Sax 7. Age (In yrs. last birthday) 65 Yrs 9. Birthplace (State or Foreign UNK Country) Days 1 ☐ M 💥 F Director Yrs. 218-36-6966 Jul. 23, 1940 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-1 ehow 7 is marked other then "netural", or items 23e or 28e-1 ehov treumetic event, the Macical Examinar must be multified at Director XXYes 2 □ No Md. Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 11W. 20th Street Funerai 21218 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, GiveX Year or Dates: Saltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: þ SpeciBlack 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Day Care Provider Self 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Robert Ireland Margret (Rorey) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Item 27 I Kim Wilson (Daughter) 8716 Fountainer Lane, Baltimore, Md. 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ★ Burial 2 □ Cremation 3 □ Removal from State ō Importent: If It any injury or o once. ☐Donation 5 ☐ Other (Specify) Mt. ZionCemetery 11/09/2005 Landsdowne Maryland 22. Name and Address of Facility James E. Lincoln F/H PA 21. Signature of Funeral Service Licensee 108 W. North Avenue, Baltimore, Maryland 21201 Me Nevica 26a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician disease or condition resulting in death) 2 Week /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner death certificate be executed the burial-transi Due to (or as a consequence of): Box 68760, physician Physician/Medical use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death signed by the a 5 Other (specify) P.0. 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed uss 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? prop.c 1 Yes of Vital 2 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospitel or Attending After 1 Natural 5 Pending within 24 hours after death. To the Funerel Director: A 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signature and title certifier 0 29d. Date signed (Month, Day, Year) 127569 30. Name and address of persons of death (Item 23a) (Type, Print) completed ca 38 Greene True Red ettlemus 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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Directo

by Funeral

Completed

Be

traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be tiled within 72 hours after death v Department of Health and Mental Hygiene Important: If Item 27 is marked other than "natural", or Iteme 23a any njury or other traumatic event, the Medical Examinar page.

Baltimore, Maryland 21215-0036

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):	
resulting in death) Last	Due to (or as a consequence of): d.	
fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. ff yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery Month Day Year
HYPERTE		23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
CORONAR	Y ARTERY DISEASE.	24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 Yes 2 Y
25. Was case referred to medical examiner?	26. Place of Do	eath Check only one
1 Yes 2 No	Hospitaf: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Mann o Death 1 Vinatural 5 Pending 2 Accident investiga		28d. Describe how injury occurred
3 Suicide 6 Could no determin	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the best of my knowledge, death occurred at the time, date and plac caminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	ce, and due to the cause(s) and manner as stated. curred at the time, date and place, and due to the cause(s)
29b. Signature and title of certifier	A: MASOOD, MD. P-1950	29d. Date signed (Month, Day, Year) NOVEMBER 2, 260 C.

CATENS

A-VE, BAZTIMORE MO 21244

State Registrar

AWAIS

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MASOOD MO,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 0 5 35809 Certificate of Death 2. Date of Death 3. Time of Death MT1- 2-05 **Physician** ena Vilson 4:55*P* × /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore If Under 1 Year | If Under 24 Hrs. last birthday) 8. Date of Birth **Funeral** (State or Foreign 90 onth 9.y. Months Days Hours 1 ☐ M 2 😿 F Director with the Maryland 10c. City, Town or Location r than "natural", or iteme 23a or 28a-f ehow the Medical Examinar must be notified at 10d. Inside City Limits Baltimore 1 ☐ Yes 2 No Director nmore 10e. Street and Num 10f. Zip Code 10g. Citizen of What Country? 5605 21207 Funerai permit. Peges 1 end 2 should be filed within 72 hours after deet Department of Health and Mental Hygiene. Important: if item 27 is marked other the any njury or other trainment. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No by Specify: 3 Widowed 4 □ Divorced DIGC Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Kind of Business/Industry (Give kind of work done life. DO NOT se retire Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be anes 19b. Mailing Auress (Street and Number or Rural Route Number, City or Town, State, Zip Code) Homire, MD 2/207 20a. Method of Disposition

1 ABurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licerse ervices MD 21133 23a. Part1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** 18an /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed ettending physicien and for use as the buriel-translt resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death signed by the eld be detached for 5 Other (specify) 9 Unknown copditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, cete hes been signate. 2 No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available phor to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Osteoporosis Division of Vital 2 No or Attending Physician: 25. Was case referred to medical examiner? tor: After this certifi the funeral director 26. Place of Death | Check only one) Hospital Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 No Medicai Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Injury efter death. 1 ☐Yes 2 ☐No investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281 Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital o within 24 hours eff to the Funeral Di completely filled in 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number no completed cause of death (Item 23a) (Type, Print) Susan J Hen west Northern Parkary vit 101

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

			1 - For State Registrar	State of M	larylar			nt of H		nd Me	_	giens	บบอ	35	810
	Dhugie		1. Decedent's Name (First, Middle	, Last)						2	2. Date of De Month	ath Da	y Year	3. Tim	e of Death
3	Physic /Medi		Louis A. Wood				,			c	CTOBE		9,2005	5 4:	25 PM
2	Examir	ner	4a. Facility Name (If not institution	, give street and number)		4b. City	, Town, or	Location of	Death		4c	County of Dea	th	
		128	ST AGNES H						CRE >		D				
	- Funeral		5. Social Security Number	6. Sex 7. A 1⊠M 2□F	ge (in yrs. 84	last birthday) Yrs.	Months		If Under 24 Hours	Min.	. Date of Bird (Month, Da	h y, Year)	9. Bir	ountry)	ate or Foreign
15	Director		214-18-2909 Usual Residence of Decedent		04					ψı	une 28	, 15	21 Mar	yland	
	/land		10a. State 10b. County		10c. C	ity, Town or Lo	ocation							10d. Insid	e City Limits
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	dea dea	ner	11. Marital Status	12. Was Decedent Armed Forces		J.S. 13.	Was Dece	dent of His	spanic Origin	n? (Speci	fy Yes or No can, etc.)	-	14. Race - Ame Black, Whit		١,
98	or it	F	1 Never Married 2 Marri	ed 1 Yes 2 □	No		1 🗆 Yes		Specify:		,,		Specify:	18, 810.	
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Baltimore,	permit. Pages Department of the important: If ite eny injury or of once.		21. Signature of Funeral Service I	icensee		22	2. Name a	nd Address	s of Facility	1	CEE **	D 1		_	
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	Physician		Immediate Cause (Final disease or condition			ORES	SPIR	ATOS	24	AR	RRES	7		Onset a	nd Death
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100	P #	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	s a consec	quence of):									
	and -trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C. Due to for a	2 22 22 22						_				
8760,	ite be executed sysician and ne burial-transit	al E	,	Due to (or as	s a consec	(derice of):									
87	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rall director, page 2 should be detached for use as the burial-transit	dical		d										-	
39 X	ding se as	/Me	IF FEMALE:	23c. If yes, outcome	e of orean	ancy							004 Data -4.4-1		-
Box	atter for u	clar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Feta	aideath 3□	Ectopic p Other (s						23d. Date of del Month	Day	Year
P.O.	y the	Physician/Med	1 □ Yes 2 ☎ No 9 □ Unknown	9☐ Unknown											
	ires that the death certificate signed by the attending phys d be detached for use as the	by Pt	Part II. Dther significant condition	ns contributing to death	but not res	sulting in the u	nderlying	cause give	n in Part J.		23e. Did to	bacco u	ise contribute to	the cause	of death?
rds	quire; n sig uld be	d b	CORONARY	ARTERY	D	158A	SE.			_	104	es 2	□No 3□Pr	obably 4	∐Unknown
Records,	sw requires s been si should!	Completed	END STA	GE REN	AL_	DIS	EAS	G.,			24a. Was	an	24b. Were au	itopsy findin	igs available
Re	The It	mo							- 4.00	_	autop	med?_	death?		of cause of
ta	an: tifica tor, p	0	CHRONIC 25. Was case referred to medical	OBSTRUCT	100	AIRU	URY	רוח	26 Place of		1 ☐ Yes Check only o	2 No	1 ☐ Yes	2□ No	
of Vital	ysici is cer direc	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ient 2	ER/Outpatier	nt 3 Do	OA Othe					6 ☐Other (Spe	cify)	
0	ding Physician: The lav h. After this certificate has funeral director, page 2.3		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury av Year)	28b. Time of	f :	28c. Injury Work			d. Describe h			,/	
Ö	Attending or death.	atic	2 Accident investig	ation	,	,,	М		es 2 □ No)					
Division	r Att	Certification:	3 ☐ Sutcide 6 ☐ Could r 4 ☐ Homicide determi		ijury - At h	ome, farm, str	eet, factor	y, office		281	Location (S City or Tox	treet an	d Number or Ru	ıral Route ∧	lum <i>ber,</i>
	ital o	Ç													
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	Check only 2 Medicai	g Physician: To the best Examiner: On the basis of	ot examina	owledge, deatl ation and/or in	h occurred vestigation	at the time	a, date and a	place, and occurred	d due to the d	ause(s)	and manner as	stated.	ie(s)
	the the	Med	one) 29b. Signature and title of certifier	and manner s	tated.			c. License							
	or To To		A dan	~ mn			29			4 ^			e signed (Monti		,
,			30. Name and address of person	the completed	doorb (tr	m 22c) (7	Deice)	H 7	95	τ_O		000	CBER	292	2005
			YASMIN ALI		-			d III	LITILA	A PC	900 0	AT	(A VIDE CO	ler pa	21229
44	s ³	ite.	31. Date filed (Month, Day, Year)	32 Regist		ature		2 -16 V	TUTTE	MES	100 6	HICH	ANN I BA	IC/ IXM/C	KEIMD
	Regist		MOV 0 7	2005	5. A	y. An	and i								

State of Maryland / Department of Health and Mental Hygiene 358 H Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** OCTOBER PEGGY KILLMON 20. 2005 11:40 AM /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Neme (If not institution, give street end number) Examiner 2515 STOCKTON ROAD POCOMOKE CITY WORCESTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Deys Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. lest birthday) **Funeral** Months 1□M 2以F 70 Yrs. 230-34-6859 VIRGINIA Director DANUARY 6. 1935 Usuet Residence of Decedent tha Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. Stete 10b. County items 23s or 28s-f show traumatic event, the Medical Examiner must be uptitled a 1 ☐ Yes 2 No Director POCOMOKE CITY MARYLAND WORCESTER 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 2515 STOCKTON ROAD 21851 U.S.A. Funeral Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 🔯 No 1 Never Married 2 Married 1□ Yes 2 No Specify. Specify: WHITE If Yes Give 2 3 Widowed 4 Divorced Year or Dates: Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER DOMESTIC 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be RENTHIA PRUITT **GLENWOOD** KILLMON 2 19a. Informant's Name/Relationship (Type, Print) 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2517 STOCKTON ROAD, POCOMOKE CITY, MD LINDA LAYTON/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/24/05 SALISBURY, MARYLAND SALISBURY CREMATORY 21. Signature of Funeral Service Licenses 22. Name and Address of Facility WILLIAMS FUNERAL HOME, 25046 PARKSLEY RD., PARKSLEY, VA 23421 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediete Cause (Final GartiL anegryim disease or condition resulting in death) Examiner Due to (or es a consequence of): Physician/Medical Examiner hypertension or Attending Physician: The law raquires that the deeth cartificate be executed usa as tha burial-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 2 funaral director, paga 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No this cartificate 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 MResidence 6 Other (Specify) 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 1 Naturel 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After 5 Pending investigation after daath. Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident tha 28f. Location (Street end Number or Rural Route Number, City or Town, State) To the Hospital or Atter within 24 hours after dar To the Funeral Director complataly filled in by th 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier end manner steted. 29d. Date signed (Month, Day, Yeer) 29c. License number 29b. Signature and title of certifier 0101035244 VA - M 10/24/05 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) 23416 CALC HALL MD PO SOY 130 UL DAVID HOTHING

Registrar DHMH 16 Rev 6/95

State

31. Date filed (Month, 1907 par) 2 4 200 532. Registrar's Signeture

		•	1 - For State Registrar		State of M	laryland		artment of H <i>rtificate of l</i>			giene Reg: No.	05	35812	
	Physicia	. n	1. Decedent's Name (Firs	t, Middle, Last)						2. Date of Dea Month	ath Day	Year	3. Time of Death	
	/Medic	al	Catherin		Atchis			4 6h Taua	A continue of Day	Oct	16	2005	9:52 P	VI.
4	Examin	er	4a. Facility Name (If not in	_				4b. City, Town, or		un	PG	County of Deat	1	
1	Funeral		Prince Ge 5. Social Security Number	f 6. Sex	7. A	<u>1.</u> ge (In yrs. la	st birthday)	Chever If Under 1 Year Months Days			h	Q Rint	nplace (State or Foreig	gn
	Director		577-58-527	9	M 2126F	62	Yrs.	WIOTHIS Days	riodis iviii	Aug 30	194	3 Nor	th Carol	_
	land ow		Usual Residence of Dece 10a. State 10b.	County		10c. City	, Town or Lo	cation					10d. Inside City Limit	s
	Many B-1sh	tor	Md PG			Uppe	er Ma	r1boro					1 □Yes 2XN	0
	or 28.	Sire	10e. Street and Number				_	10f. Zip Code			10g. Citiz	en of What Co	untry?	
	ath w	rai	12603 Whi					20774_			USA			
21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Haalth and Mental Hygiena. Item 27 is marked other than "naturel; or Itams 23e or 28e-f show other traumatic event, the Modified Examinating the notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 3 ☐ Widowed 4 ☐ □	Married	12. Was Deceden Armed Forces 1 ☐ Yes 2 X If Yes, Give Year or Dates:	? [No		Was Decedent of H f Yes, specify Cuba I □ Yes 2 [™] No	ispanic Origin? (in, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)		4. Race - Ame Black, White Specify: B1	e, etc.	
5-0	72 h	etec	15. D (Specify on	Decedent's Educ ly highest grade	cation completed)		16a. Deced (Give	tent's Usual Occup kind of work done o DO NOT use retired	ation during most of wo	orking	16b. Kin	d of Business/	ndustry	
121	within ena. than	Completed	Elementary/Secondary	(0-12)	College (1-4or		ا المالة Foldi			I	IIS	House	of Reps	
	i filad I Hygi other ent, I	Be Co	17. Father's Name (First,	Middle, Last)		!·	0101	iig vide		me (First, Middle,			or Keps	
/lan	2 should ba filad withir and Mental Hygiena. Is markad other than aumatic event, ILE M.	To B	Wilson Nel	Lson					Clare	ase Bea	rd			
Maryland	2 sho and I Is ma		19a. Informant's Name/R		*	- 3		•					ip Code 20774	
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Baltimore,	8 7 = 9		1X Burial 2 ☐ Cre 14 ☐ Donation 5 ☐ 0	mation 3 🗆 R	emoval from State	g C6	metery, crer	natory or other place oln Ceme		22,05		-		
altii	mit. Parpartmen sortant: / injury 29.		21. Signature of Funeral		1	T. C.) 22	. Name and Addres	ss of Facility T	yrone 3	J. Y	oung E	un Ser.	
ä	Departing Department of the subset of the su		Liston	e A	: Hal	mes		19 Fenne	dy Str	eet NW	Was	h DC 2	20011	
			23a. Part 1 Eyter the dis shock, or heart failu	ease, or loo pli ire. List of or	cat se that cause ne case on each	ed the death line.	o not ent	er the mode of dyin	g, such as cardia	ac or respiratory ar	rest,		Approximate Interval Between Onset and Death	
	Physician /Medical		Immedia ause (Final disease or condition resulting in death)	- 8				Arrhyt	hmia					
В	Examiner		Due to (or as a consequence of): Sequentially list conditions, b. Ischemic Heart Disease											
		ner	Sequentially list condition cause. Enter Underlying Cause (Disease or injury that initiated events	ns, ate	Due to (or a									
	ecuter and -trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	٥	Due to (or a	s a consequi	ence of):							
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687	- 70 4	edical												
.O. Box	attandin for use	Physician/M	IF FEMALE: 23b. Was decedent preg in the past 12 month 1 ☐ Yes 2 ☒No 9 ☐ Unknown	nant	3c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)			23	3d. Date of deli Month	very Day Year	
Θ,	w requires that the de been signed by the should ba detached	by P	Part II. Other significant	conditions cor	ntributing to death	but not resu	tting in the u	nderlying cause give	en in Part I.	23e. Did to	obacco us	se contribute to	the cause of death?	
ord	requires een sign nould ba	ted			-					1 🗆 1	res 2□	No 3∏Pr	obably 42 Unknow	n
al Records,	The lay	Completed										prior to death?	topsy findings availab completion of cause of 2 \(\sumbole\) No	le
of Vital	Physicien: The this certificate ral director, pag	o Be	25. Was case referred to examiner? 1 Yes 2 No	-	lospital: 1 🔀 Inpat	iont all	EP/Outpatier	at 3 DOA Oth	or	eath (Check only on Home 5 Resident Res		Cothes (Cons	1.4.4	
of		n; To	27. Manner of Death		28a. Date of In (Month, D		28b. Time of	-		28d. Describe h			ary)	-
ion	Attending r death. sctor: After oy the fune	atio	2 Accident	Pending investigation	(Worth, D	ay roar,	Injury		Yes 2 □ No					
Division	Dire	Certification;	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Place of li building, e	njury - At ho atc. (Specify	me, farm, str	eet, factory, office		28f. Location (S City or Tox		Number or Ru	ral Route Number,	
	Hospitel		29a. Certifier 1X	Certifying Phys	sician: To the bes	t of my know	viedge, deatl	n occurred at the tin	ne, date and plac	ce, and due to the	cause(s) a	and manner as	stated.	
	the Ho iin 24 I the Fu ipletely	Medical	one)		ner: On the basis and manner s	of examinat stated.	ion and/or in	vestigation, in my e				-1		
	With To I	2	29b) Signature and title of	dertifier	000	770		29c. Licens	/ .		29d. Date	signed (Month	n, Day, Year)	
0			30. Name and add ss of	Chu person who co	mpleted cause of	death (Item	23a Tvne	Print)	1 De	4259	17	119/0)		
_	(0)		David Is	•	·		ver F	/	Suite	101,Su	iitla	and Mo	.20746	
	Sta		31. Date filed (Month, Da	y, Year)	32 Regis	trar's Signat	ure							
'	Regist	ar	UUT	2 4 200) Bease	101 14	65	uli						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 5 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 22, 9:45 P M October 0 William S. Adams 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Months 1**XX**M 2□ F 72 May 23, 1933 Maryland Director 213-30-9791 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f ehov ner must be notified at 1 Yes 2X No Maryland Howard Columbia Columbia Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9409 Farewell Road 21045 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? th and Mental Hygiene. If Is marked other than "natural", or Items traumatic event, the Medical Examiner m 14. Race - American Indian, Black, White, etc. 1 □XYes 2 □ No If Yes, Give Year or Dates: 1950-52 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【No Specify: Specify: African American 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Chief of School Bus Operations Public Schools Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William Thomas Adams Mary Penny Jenkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9409 Farewell Road Columbia, MD 21045 Carolyn Adams/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition October Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State W. Arundel Crematory 25, 2005 Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatore of Funeral Service License 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic Prostate Cancer YCAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (u. as a consequence of) physicien and s the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day al Records, P.O. B 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

Jason Black 31. Date filed (Month, Day, Year) 0CT 25

200 / Xack

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

2005

Octob

29c. License number

20061199

6565 North Charles ST, Suite 203 Touson MD 21204

29d. Date signed (Month, Day, Year)

			For State Registrar	State o	of Maryla		artment of I		nd Mental H	ygiene		35814
3	Physici		1. Decedent's Name (First, Middle,		ncent		Alexo	inder	2. Date of I Month Octob	Death Da	y Year	3. Time of Death 5:00 P M
	/Medio Examir		4a. Facility Name (If not institution, Shady Grove Adv	give street and nu rentist I	_{mber)} Hospita		4b. City, Town, Rockvil	or Location of	Death	4c	County of Dea	
8.3	Funeral Director		5. Social Security Number 552-68-9178 Usual Residence of Decedent	Sex 1₩ 2□F	7. Age (In yrs	Yrs.	If Under 1 Year Months Days		Min. (Month,	Day, Year)	C	nthplace (State or Foreign ountry) alifornia
	r 28a-f show	Director	10a. State 10b. County Maryland Montgome 10e. Street and Number	ery		aithers				10g. Cit	izen of What C	10d. Inside City Limits 1 ☐ Yes 2 ☑ No ountry?
336	72 hours after death with the Maryland natural; or items 23s or 28s-f show disal Examinat must be notified at	by Funeral D	10123 Nighting 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dec Armed For 1 Yes	edent Ever in		20882 Was Decedent of If Yes, specify Cub		n? (Specify Yes or I Puerto Rican, etc.)	USA No-	erican Indian, ite, etc. White	
Maryland 21215-0036	I within piene. r than "	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12	Education grade completed) College (16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire	during most o	-	Ret		s/Industry
laryland	0 = 0 5	To Be	17. Father's Name (First, Middle, La Karl Lanier Ale 19a. Informant's Name/Relationship	xander		19b. Mailir	ng Address (Stree	Mae 1	s Name (First, Midd Frances Mi or Rural Route Num	oran		Zip Code)
Baltimore, N	permit. Pages 1 and 2 should be Department of Health and Ments Importent: if Item 27 is marked any injury acapter traumatic enone.		Mrs. Judith M. 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	□Removal from	State 20b.	Place of Dispo cemetery, crea	7 Repris sition (Name of matory or other pla	ce)	Date D/25/2005	20c. L	ocation - City or	Town, State
Balti	permit. Departn Importe any inju		21. Signatur of Fune al Service Li	Jasch-	Your	1	2. Name and Address 040 Rock	ess of Facility ville I	Simple Tr Pike Rocky	ribut ville	e Funer	al Home 52
	Physician /Medical		23a. Part1. Enter the disease, or of shock, or heart failure. List or immediate Cause (Final disease or condition resulting in death)	aSe	caused the date each line.	Shock	er the mode of dy	ng, such as ca	ardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
8760,	eate be executed physician and the burial-transit	Icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	. Ac	(or as a conse	l caholi	en dise	ease patitis				1 month 1 month
O. Box 6	death certifi e attending p id for use as	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1☐Live I	atcome of pregr birth 2 ☐ Fet nant at time of nown	tal death 3	Ectopic pregnanc Other (specify)	у			23d. Date of de Month	olivery Day Year
<u> </u>	w requires that the been signed by th should be detache	ρ	Part II. Other significant condition	s contributing to d	leath but not re	sulting in the u	nderlying cause gr	ven in Part I.			_ 7	o the cause of death? robably 4 Unknown
al Reco	The law ate has b page 2 st	Completed							24a. We au pe 1 Yes	topsy formed?	24b. Were a prior to death?	utopsy findings available completion of cause of
Division of Vital Records,	ding Phys h. After this funeral di	ition: To Be	25. Was case referred to medical examiner? 1 Yes 20 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date (Mon	- 34	ER/Outpatier 28b. Time of Injury	28c. Inju	ner: 4 🗆 Nurs	of Death (Check only sing Home 5 \subseteq Re 28d. Describ	sidence		ecify)
Divisi	in Life	Certification:	3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place	e of Injury - At I ling, etc. (Spec	home, farm, str lify)	eet, factory, office			(Street ar own, State		ural Route Number,
	To the Hospitel or At within 24 hours after or To the Funerel Directompletely filled in by	edical	(Check only 2 Medical Ex	t aminer : On the b	e best of my kr pasis of examin nner stated.	nowledge, death nation and/or in	vestigation, in my	opinion, death	place, and due to the occurred at the time	e, date and	place, and du	e to the cause(s)
	10 5 # 5 8	2	29b. Signature and title of certifier			CIAN	29c. Licen:		-8-		to ber	
				stogi	, MD		Print) 9901 N	ledica	1 Centa	Dr.	Rocl	19,2005 coille, MD
	Sta Registr	-	31. Date filed (Month, Day, Year)	2005	registrar's Sign	nature	462					

			1- State of Maryland / Department of State of Maryland / Department of Certificate	of Health and Me of Death	ental Hygiei Reg.		35815
			1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Vasa	3. Time of Death
	Physici: /Medic		Dorothy M. Austin	C		10 2001	5 9:25 am
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, To	wn, or Location of Death		4c. County of Dea	ith
			11109 Fruitwood Drive Bowi	e	Þ	rince G	George
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1	Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	ar) 9. Bii	thplace (State or Foreign ountry)
	Director		578-36-3343 74 Yrs.		Mar 22,1	931 DC	
	pur *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	faryla sho	5					1⊠Yes 2 □ No
	28a-1	Director	Md. Prince George Temple Hill 10e. Street and Number 10f. Zip Cc	nde	100	Citizen of What C	ountry?
	with te or						· · · · · · · · · · · · · · · · · · ·
	leath	era	4704 23rd Parkway #Apt 21 2074 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Deceden	t of Hispanic Origin? (Spec	cify Yes or No-	USA 14. Race - Am	
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If Item 27 Is marked other than "naturel", or Items 23a or 28a-f show any injury or other traumatic event, Ite Modical Examiner must be notified at once.	by Funeral	Armed Forces? If Yes, specify 1 □ Never Married 2 ☒ Married 1 □ Yes 2 ☒ No 1 □ Yes 2 ☒ No 1 □ Yes 2 ☒ 1 □ Yes 2 ☐ 1 □ Yes 2 ☐ 1 □ Yes 2 ☐ 1 □ Yes 2 ☐ 1 □ Yes 2 ☐ 1 □ Yes 2 ☐ 1 □ Yes 2 ☐ 1 □ Yes 2 ☐ 1	Cuban, Mexican, Puerto R	Rican, etc.)	Black, Whi	te, etc. lack
ŏ	2 hou	ted	15. Decedent's Education 16a. Decedent's Usual C			. Kind of Business	/Industry
21215-0036	i within 73 iene. r than "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) PhD 8yrs (Give kind of work of life. Do NOT use in the l		- 50	pervise ocessii Gov't	or Data ng,
ğ	a filec if Hyg othe /ent,	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name			
ā	uld be fenta rked tic ex	To B	James Wallace Cross	Dorothy	Jiles		
Maryland	short and N sma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (S	treet and Number or Rural	Route Number, Cit	ty or Town, State,	Zip Code)
Σ	and 2 salth n 27 l		Willatant Austin(Husband) 4704 23rd	A STATE OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF T			
ore C	of He		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name cametery, crematory or other	of Da r place)	ate 20c.	. Location - City or	Town, State
altimore,	Pag ment ent: I ury o		'4 □ Donation 5 □ Other (Society) Arlington Nat	'1CemNov (01,05 Ar	lingto:	n, Va.
Balt	permit. Departi Import any inj		throne f. yallne Tyrone	Address of Facility J. Young 7		nedy St	NW Approximate
L	Pnysician		shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	f dying, such as cardiac or			Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of):				
		_	Sequentially list conditions, if any, leading to immediate b. Carcinoma Due to (or as a consequence of):				41/2
_	ted	in	Cause. Enter underlying Cause (Disease or injury				
	axecu and al-tra	Examiner	that initiated events c				
8760,	cate be executed physician and i the burial-transit	dlcal	d				
89	tificat g phy as th						
P.O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnant at time of death 5 □ Other (special pregnant at time of death 9 □ Unknown			23d. Date of de Month	livery Day Year
	that t	P P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	e given in Part I.	23e. Did tobaco	o use contribute t	o the cause of death?
rds	quires n sigr uld be	ed by			1 ☐ Yes	2 □ No 3 □ P	robably 4XIUnknown
Division of Vital Records,	2 2 8	Completed			24a. Was an autopsy performed 1 Yes 2 🔀	? prior to death?	utopsy findings available completion of cause of
ā	ien: rtifica stor. F	BeC	25. Was case referred to medical examiner?	26. Place of Death			
>	Physic this ce al direc	2	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 Nursing Hom	ne 5 X Residence	6 □Other (Spe	ecify)
o uo	Attending Physicien: r death, ector: After this certifics by the funeral director, I		27. Manner of Death 1 🖾 Natural 5 🗆 Pending 2 🗀 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M	Injury at Work? 1 Yes 2 No	8d. Describe how in	njury occurred	
Divis	tel or Atte s after de el Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, o building, etc. (Specify)	ffice 21	8f. Location (Street City or Town, St		ural Route Number,
	To the Hospitel or Attending Physicien: The within 24 hours after death, To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Medical (29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at 1 Certifying Physicien: To the best of my knowledge, death occurred at 1 Certifying Physicien: To the best of my knowledge, death occurred at 1 Certifying Physicien: To the best of my knowledge, death occurred at 1 Certifying Physicien: To the best of my knowledge, death occurred at 1 Certifying Physicien: To the best of my knowledge, death occurred at 1 Certifying Physicien: To the best of my knowledge, death occurred at 1 Certifying Physicien: To the best of my knowledge, death occurred at 1 Certifying Physicien: To the best of my knowledge, death occurred at 1 Certifying Physicien: To the best of my knowledge, death occurred at 1 Certifying Physicien: To the best of my knowledge, death occurred at 1 Certifying Physicien: To the best of my knowledge, death occurred at 1 Certifying Physicien: To the best of my knowledge, death occurred at 1 Certifying Physicien: To the best of my knowledge, death occurred at 1 Certifying Physicien: To the basis of examination and/or investigation, in and manner stated.	my opinion, death occurred	d at the time, date a	e(s) and manner a and place, and du	s stated. e to the cause(s)
	To the within To the comple	Σ		icense number D, C		Date signed (Moni	·
			M SC SIM	D32574	0	et 19,	2005
	(4)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John C. Elkas, MD, Walter P	D32574 Washing eep AMC, L	gton Oc 0900 Geor	aja Ave.	NM -5001
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 1 2005 Registrar's Signature.		0-1	J	

		For State Registrar		aryland / Dep <i>Ce</i>	artment of I	Health and Death	R	leg. No.	.
Physici	an	Decedent's Name (First, Middle, L.	ast)				2. Date of Dea Month		3. Time of Death
/Medic	al		JOHN	PAUL		HOFF	OCTOBE		
Examin	er	4a. Fecility Name (If not institution, g				or Location of Dea	th	4c. County of	
		1296 BRUCEVILLE 5. Social Security Number 6.		e (In yrs. last birthday	KEYMAI		8. Date of Birth	CARROLI	Birthplace (State or Foreign
Funeral Director		179–20–7505	157M 2016	76 Yrs.	Months Days			, Year)	Country)
		Usual Residence of Decedent					APRIL 4	1949	NEW YORK
rylan		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
e Ma Sa-f s	cto	MARYLAND CARE	OLL	KEYMAR					1 ☐ Yes 2 No
ith th	Dire	10e. Street and Number			10f. Zip Code		1	l 0g. Citizen of Wha	at Country?
a 23e	rai	1296 BRUCEVILI	7		2175			U.S.A.	
ter de Itam narr	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces? 1 ☑ Yes 2 ☐ I		If Yes, specify Cub	hispanic Origin? (ban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		American Indian, White, etc.
ING 21213-0036 be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Itama 23a or 28a-f show event, the Medical Examinar must be notified at	by F	1 ☐ Never Married 2 ★ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	10	1 ☐ Yes 2 🔀 No	Specify:		Specify:	WHITE
2 hou	ted	15. Decedent's			edent's Usual Occu			16b. Kind of Busin	ness/Industry
Z Later of the Paragraph of the Paragrap	Completed	(Specify only highest g	rade completed) College (1-4or 5	life	e kind of work done DO NOT use retire	during most of word)	orking		
Z with a second	ЮП			'	ELDER			TOOL N	ÆG.
be file tal Hy doth	Be (17. Father's Name (First, Middle, Las	it)			18. Mother's Na	me (First, Middle, i	Maiden Sumame)	
	ဥ		UNKNOWN				ARY ALTHO		
2 2 a a		19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ing Address (Stree	t and Number or F	lural Route Number	r, City or Town, Sta	ate, Zip Code)
C 4 4 F		FLORENCE ALTHO	FF	20b. Place of Disp	96 BRUCES	TILE ROA	D, KEYMAI	R. MD. 21	757
O 8 ° = 5		20a. Method of Disposition 1 Burial 2 □ Cremation 3	☐Removal from State	cemetery, cre	matory or other pla	ice)		20c. Location - Cit	ty or Town, State
altimo mit. Pag partment fortant: I finjury o		`4 □Domation 5 □Other (Spec		RESTHAVE			1/05	FREDERIC	K, MD.
Balti permit. I Departm Importa any Inju		21. Signature of Funeral Service Lic	ensee A		2. Name and Addr		KILES FUN		
		23a. B. T. Enter the disease, or co	mplications that caused	the death. Do not en	136 E. BA	LTIMORE	ST., TAN	EYTOWN, M	D 21787
2811		h xk, or heart failure. List on	y one cause on each li	ne.	itel the mode of dy	ing, such as cardia	ic or respiratory arr	est,	Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a	rund	CONCES	۷.			2 months
Examiner			Due to (or as	a consequence of):					
	ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence of):					
ate be executed hystoian and the burial-transit	Examiner	Cause (Disease or injury that initiated events	C						
60, be executed ician and burial-transit	Exa	resulting in death) Last	Due to (or as	a consequence of):					
s/60 ate be e nysiciar he buria	icai		d						to soule in
Hecords, P.O. Box 687. The law requires that the death certificate the has been signed by the attending phys bage 2 should be detached for use as the	Physician/Med	IF FEMALE:							
BOX 68 eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnanc	y		23d. Date of Month	•
tr the death true by the a tached for	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death 5	Other (specify) _			I I I I I I I I I I I I I I I I I I I	Say Foat
hat the deface detace		Part II. Other significant conditions	contributing to death h	ut not resulting in the I	Inderhijna cause ar	von in Part I	23e Did tol	hacco use contribu	ite to the cause of death?
ecords, P law requires that as been signed t	d	C A	~~~ A	'	l ase	voil ili Fait i.	1	_	☐ Probably 4 ☐ Unknown
r requ	etec	0.1	- ` ^-						
II HeC	Completed		romi A	rai Eb	nuetion		24a. Was a autops perforr	in 24b. Wei sy prio med? dea	re autopsy findings available r to completion of cause of th?
		M	on - Model	ins Lum	apons		1 ☐ Yes 2	2 ∑ No 1□	Yes 22No
	o Be	25. Was case referred to medical examiner?	Hospital:	- 0 C C C C C C C C C C C C C C C C C C	-t 00 -c. Ot	hor	ath (Check only on		(0)()
O & 눈물	To it	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Inju	nt 2 ☐ ER/Outpatie	III JU DOA	4 Nuising	Home 5 Reside	ow injury occurred	(Specify)
DIVISION (I or Attending F after death. Director: After din by the funeral	tlor	1 Natural 5 Pending 2 Accident investigati	(Month, Da	ý Year) Injury	of 28c. Inju Wo	rk?]Yes 2 □No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Atten dea octor	fica	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of Inj	ury - At home, farm, st	treet, factory, office		28f. Location (St	reet and Number	or Rural Route Number,
DIVISION tall or Attendir is after death. all Director: All ed in by the fu	Certification:	4 Homicide	building, et	c. (Specify)			City or Towr	n, State)	
Hospital 24 hours a Funeral I tely filled		29a. Certifier 1X Certifying	hysician: To the best	of my knowledge, dea	th occurred at the ti	ime, date and plac	e, and due to the ca	ause(s) and mann	er as stated.
To the Hospital of within 24 hours af To the Funeral D completely filled in	edical	(Check only 2 Medical Excore)	aminer: On the basis of and manner sta	examination and/or in	ivestigation, in my	opinion, death occ	urred at the time, d	ate and place, and	due to the cause(s)
To the within 2 To the complet	Σ	29b. Signature and title of certifier	$\Lambda\Lambda$		29c. Licen	se number	2	9d. Date signed (#	Month, Day, Year)
)~	1 + Jon	J. 6	•	043643	3	OCTOBER	29, 2005
1xa		30. Name and address of person wh			, Print)				
10.		ASON,	A. TATE		e very	0.	the every	in wo	51783
Sta Registr		31. Date filed (Month, Day, Year), NOV 0 4	2005 32. egistr	ar's Signature					
DHMH 17 Rev 1/2			Market	UDA					
	551			ORIGIN	AL				

		•	1 - State Registrar	State of Maryland / Depa	artment of Health and M rtificate of Death	lental Hygie								
			Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death							
	Physici		Bruce Burke			October :	Day 2005 3:00 P M							
	/Medic Examin		4a. Fecility Name (If not institution, give s	treet and number)	4b. City, Town, or Location of Death		4c. County of Death							
			6129 Stevens Fo	rest Road	Columbia		Howard							
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9 Birthplace (State or Foreign							
	Director		029-30-9956	M 2□ F 64 Yrs.	Months Days Hours Min.	(Month, Day, Y Dec 29,	1940 Massachusetts							
Į.	P .		Usual Residence of Decedent											
	show	_	10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits							
	8e-f.	cto	Maryland Howard	Columbia			1 ☐ Yes 2 🛣 No							
	or 23	Director	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Country?							
	23a		6129 Stevens Fores	t Road	21045	US	SA							
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or itams 23a or 28e-f show appringing or other traumatic event, the Medical Examinar must be notified at an ance.	by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 Kn Yes 2 □ No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify:							
21215-0036	hour tural	pe pe	15. Decedent's Educ		dent's Usual Occupation	16	Specify: White b. Kind of Business/Industry							
<u> </u>	n 72	Completed	(Specify only highest grade	completed) (Give	kind of work done during most of worki DO NOT use retired)	ng	b. Kind of Business/Industry							
12	withi ene. then	m d	Elementary/Secondary (0-12)	College (1-4or 5+) 5+ Engir		R	Research							
0	filed Hygi ther ant,		17. Father's Name (First, Middle, Last)	Ji Ingri		(First, Middle, Ma								
an	d be antal	To Be	Joseph Burke		Mildred	Ricker								
Maryland	shoul mark mati	Ĕ	19a. Informant's Name/Relationship (Typ	ne. Print) 19b. Maili	ng Address (Street and Number or Rura		City or Town. State. Zip Code)							
≥	nd 2 s lih ar 27 la 27 la													
ē,	Hea Hea tem		Kathleen J. Burke/ 20a. Method of Disposition	20b. Place of Dispo	Stevens Forest Roy sition (Name of matory or other place) Octo		c. Location - City or Town, State							
<u></u>	ages int of t: If ii		1 ☐ Burial 2 【☐ Cremation 3 ☐ Ro `4 ☐ Donation 5 ☐ Other (Specify)	anioval iloni State	el Crematory 200		lenton, Maryland							
Baltimore,	artme artme ortan injury		21. Signature of Funeral Service License											
Ba	permi Depa Impo any ir		1. Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029											
	_		23a. Part1. Enter the disease, or compli	cations that caused the death. Do not ent	everly L. Heckrotte	e, P.A. C	Clarksville MD 21029 Approximate							
			shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.		,	Interval Between Onset and Death							
	Physician /Medical		disease or condition resulting in death)	Hon Small Ce	Il Lung Con	cor	10 month							
P	Examiner			Due to (or as a consequence of):)									
ь		10	Sequentially list conditions, if any, leading to immediate gause. Enter Underlying	Due to (or as a consequence of):										
	ted nsit	Examine	Cause (Disease or injury											
•	xecu and	xar	that initiated events cresulting in death) Last	Due to (or as a consequence of):										
68760,	icate be executed physician and s the burial-transit													
387		edical												
	death certific e attending p od for use as	/Me	IF FEMALE:	3c. If yes, outcome of pregnancy			23d. Date of delivery							
Вох	atter I for u	Physician/M	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy Other (specify)		Month Day Year							
Ò	0 4 6	ıysi	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown										
ص	law requires that the de as been signed by the a 2 should be detached f		Part II. Other significant conditions con	tributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?							
ds	signe d be	d by				1 ☐ Yes	2 No 3 Probably 4 Unknown							
Ö	w requir been si should	ete				24a. Was an	24h Wasa autonou findings available							
3e	0 4 0	Completed				autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?							
a	ian: The l rtificate ha			· · · · · · · · · · · · · · · · · · ·			No 1 □ Yes 2 No							
Vital Records,	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	ospital:	26. Place of Death Other: 4 All Aluccing Hos	1								
of	Phys this al dir	은	1 Yes 2 No	1 ☐ Inpatient 2 ☐ ER/Outpatier 28a. Date of Injury 28b. Time o	IL 3 DOA 4 INDISING HOL	me 5 Fesidence 28d. Describe how								
	ng fter ine	lo lo	1 Natural 5 Pending	(Month, Day Year) Injury	f 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe now	injury occurred							
Si	ten feat tor: the	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, str		28f Location (Street	et and Number or Rural Route Number,							
Division	al or Attendi s after death. al Director: A ed in by the fu	Certification:	4 Homicide determined	building, etc. (Specify)	eet, factory, office	City or Town, S								
	e Hospital or 24 hours afte e Funaral Dir etely filled in		29a, Certifier Lecertifying Phys	ician: To the best of my knowledge, deat	a occurred at the time, date and place of	and due to the saus	co(c) and manner as stated							
	24 hc 24 hc Fun stely	edical	(Check only 2 Medical Examination)	er: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurre	ed at the time, date	e and place, and due to the cause(s)							
	# = # 5	Mec	29b. Signature and title of certifier	and manner stated.	29c. License number	29d	. Date signed (Month, Day, Year)							
\	Viith Con		· Cohe		Doob2003									
,				ICAL DOCTOR		>-	DUTUBER 24, 2005							
			· ·	mpleted cause of death (Item 23a) (Type,		1-17-1 V	Δ							
	Cha		31. Date filed (Month, Day, Year)	32. Pigistrar's Signature	MO 21231	WEY T	117							
	Sta Registr			05 Alexa St. 1	Cast 1									

		•		artment of Health and Men	tal Hygier	.000 00010
	Physicia		1. Decedent's Name (First, Middle, Last) Robert William Baker		Date of Death Month Cober 2	3. Time of Death 4, 2005 4:00 A M
I	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death
	Funeral		Beverly Health Care 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		Date of Birth	Frederick 9. Birthplace (State or Foreign
	Director		228-40-7892 1□XM 2□ F 70 Yrs.		Month, Day, Yea m. 18,	
	and ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
	e Many Be-f sh	ctor	MD Frederick Brunswic	k		1 X Yes 2 □ No
	with th	Funeral Director	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?
	death	neral	1201 Maple Terrace Lane 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	21716 Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica	Yes or No-	USA 14. Race - American Indian, Black, White, etc.
36	filed within 72 hours after death with the Maryland Hygiene. other then "netural", or Items 23e or 28e-f show ent, the Medical Examiner rust be nutified at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ tNo	1 ☐ Yes 2 ☐ No Specify:	, 5.0.,	Specify: White
21215-0036	72 hou netura	sted	15. Decedent's Education 16a. Dece	dent's Usual Occupation kind of work done during most of working	16b.	Kind of Business/Industry
121	within and the "I	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		_
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Maryland	should be and Mental s marked o umetic eve	ToE	James Richard Baker	Hazel Jer		
ă Z	and 2 sh salth and n 27 is n	i i	1.7.27	ng Address <i>(Street and Number or Rural Ro</i> East "D" Street - Br	_	
ore,	- 1 5 5		20a Method of Disposition 20b. Place of Dispo		4	Location - City or Town, State
altimore,	it. Pages rtment of rtent: If it njury or o		`4 □Donation 5 □Other (Specify) Hagersto	own Crematory 10/25/	05 На	erstown, MD
Ba	permi Depar Impo eny ir		Surai A. William	2. Name and Address of Facility John Bruns	T. Willi wick, MD	
	14.7		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one caus ton each line.			Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition a			MANY YEARS
ř	Examiner					
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. (Decays or major)			
oʻ	s execu an and irial-tra		that initiated events c. resulting in death) Last Due to (or as a consequence of):		_	
8760,	icate be executed physician and s the burial-transit	dlcal	d.			
Box 6	death certificate be executed e attending physician and id for use as the burral-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □	☐Ectopic pregnancy		23d. Date of delivery
ю. В	the deally the att	ysicia		Other (specify)		Month Day Year
۵.	that ed b deta	by Ph	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ord	faw requires as been sign 2 should be	eted				2 No 3 Probably 4 Unknown
of Vital Records,	9 2	Completed			24a. Was an autopsy performed?	
ital	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?	26. Place of Death (Cf	1□ Yes 2 🔀 heck only one)	No 1 Yes 2 No
of V	S S S	은	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of		5 Residence	6 ☐Other (Specify)
ion	Attending r death. ector: After by the fune	atlon	1 Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	f 28c. Injury at Work? 28d. M 1 Yes 2 No		,,
Division	in Dire	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stream building, etc. (Specify)		Location (Street City or Town, Sta	and Number or Rural Route Number, ste)
_	Hospitel 24 hours a Funerel I stely filled		29a. Certifier 12 Cartifying Physician: To the best of my knowledge, deat			
	To the Ho within 24 To the Fu	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in one) and manner stated.	vestigation, in my opinion, death occurred a		nd place, and due to the cause(s) Date signed (Month, Day, Year)
	T wit		29b. Signature and title of certifier M. N	016675		10ct. 24,2005
	H		30. Name and address of person who completed cause of death (Item 23a) (Type,			1716
	Sta	te	31 Date filed (Month, Day, Year) 32 Registrar's Signature	- who will a bus	L (, 100
	Registr		OCT 2.5 2005 Seem & A	marke .		

State of Maryland / Department of Health and Mental Hygiege 05 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician October 21, 2005 Edgar James Burke 10:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Kline Hospice House Mt. Airy Frederick 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Sept. 23, 1919 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1**X**□M 2□F 218-09-2092 86 Yrs. Maryland Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Tyres 2 □ No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 2404 Ellsworth Way 21702 238 Unit 2D USA 2 should be filled within 72 hours after dea and Mentel Hygiene. Is marked other than "naturel", or Iteme 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 TYes 2 Now II If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 Ho Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry during most of working Elementary/Secondary (0-12) College (1-4or 5+) Salesman Food Products 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filk Department of Health and Mentel Hy important: if Item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) Edgar J. Burke Bessie Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Burke/Son 2508 Shelley Circle Unit 1D Frederick, MD 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 10/25/2005 Baltimore, MD MeadowridgeMemPark 22. Name and Address of Facility Stauffer Funeral Home, PA 21. Signature of Funeral Servid 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final disease or condition resulting in death) End Stage Alzheimers Dementia **Physician** /Medical Due to (or as a consequence of): Examiner Failure to Thrive, Immobility Syndrome Months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that interests.) Due to (or as a consequence of) Examiner this certificate has been signed by the attending physicien end rai director, page 2 should be detached for use as the burial-transit requires that the death certificate be executed Sepsis with Acute Renal Failure Weeks that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Anemia Weeks Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2XNo 3 Probably 4 Unknown Osteoarthritis Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Gastroesophagent Reflux Disease autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Residence 5 Other (Specify) Hospice 1 ☐ Yes 2 → No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No М investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🙀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Z Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of of tifler 29c. License number 29d. Date signed (Month, Day, Year) MD D-54749 OCtober 24, 2005 STIVA 23a) (Type, Print) 30. Name and address of person who completed cause of death Dr. Allen Reilly 801 Toll House Avenue, D-1, Frederick, MD 21702 32. P gistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #18 and #19a per/fh 16 Prijigate of Meath Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician 11:08 AM October 19, 2005 Vernon Glen Brake, Sr. /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Takoma Park Washington Adventist Hospital Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 **★**M 2 □ F Months Days Hours Min Yrs 78 Sept. 25, 1927 West Virginia Director 220-12-2646 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Modical Examiner must be notified at 1 Yes 2 □ No Maryland Frederick Mt. Airy Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21771 United States 14023 Prospect Road death v Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 1 Yes 2 □ No If Yes, Give 'Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White څ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education permit. Pages 1 and 2 should be filed within 7: Department of Health and Menial Hygiene. Important: If Item 27 is marked other than "na sny injury or other treumatic event, the Mude once. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Contractor **Building** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Florence Simons Florence Harry W. Brake 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Vernon Glen Brake, Jr/Son 4213 Rolling Acres Drive, Mt. Airy, MD 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 10/24/2005 Needmore, Pennsylvania Grove Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home, P.A. 21. Signature of Funeral Service Ligensee 8 East Ridgeville Blvd, Mt. Airy, MD 21771 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximale Interval Between Onset and Death Immediate Cause (Final **Physician** 40cardia weeks disease or condition resulting in death) /Medical Due to (a) as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death/but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown should Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2/ No certificate 2 No 1 🗌 Yes 1 Tyes the Hospitel or Attending Physician: director, 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ٩ 1 Yes 2 No 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 Pending 1 Tes 2 No М investigation 2 Accident Director: / 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours after To the Funeral Dire 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 36601 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maple Ave. Taking Purkus 20912 BRILL, MD M. 32. Signature 31. Date filed (Month, Day, Year) State 2005 Registrar

			1 - For State Registrar	State of Ma	arylan	d / Depa	artment of H	lealth a	and Ment	tal Hygie		35821
	Physici	20	1. Decedent's Name (First, Middle, Last)							ate of Death	Day Year	3. Time of Death
	/Medic		Earl Alman Barret							tober	22 2005	12:30 PM
	Examin	er	4a. Facility Name (If not institution, give s 1455 Colora Road	street and number)			4b. City, Town, o	r Location o	of Death		4c. County of Death	ı
	Funeral		5. Social Security Number 6. Sex		e (In yrs.	last birthday)	If Under 1 Year	if Under		ate of Birth	9. Birth	plece (State or Foreign
	Director		219-07-8030	(M 2□F	88	Yrs.	Months Days	Hours	Jak	Month, Day, Ye 1UATY 1	7,1917	MD
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	Maryl febc	tor	MD Cecil		Col	Cora						1 ☐ Yes 妆 No
	th the	irec	10e. Street and Number			***************************************	10f. Zip Code			10g.	Citizen of What Cou	intry?
	eth wi	rai	1455 Colora Road				21917				USA	
	Items	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent I Armed Forces?		.S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Ori an, Mexican	gin? (Specify ` i, Puerto Ricar	Yes or No- n, etc.)	14. Race - Amer Black, White	
980	el', or		3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 □ N If Yes, Give Year or Dates:	ww :		1□Yes 2XX No	Specify:			Specify: Wh.	ite
21215-0036	be filed within 72 hours after deeth with the Maryland ital Hygiene. id other then "neturel", or items 23e or 28e-f ehow event, the Marical Excentrar must be notified at	Be Completed	15. Decedent's Edu (Specify only highest grade	cation e completed)		16a. Deced	dent's Usual Occup kind of work done DO NOT use retired	ation during mos	t of working	168	. Kind of Business/li	ndustry
12	within ane. then	ldm	Elementary/Secondary (0-12)	College (1-4or 5	+)		DO NOT use retired LMC/L	d)			Family F	a t
<u>0</u>	i filed I Hygir other ent,	e Cc	17. Father's Name (First, Middle, Last)			1 W	.me.c	18. Mothe	er's Name (Firs	st, Middle, Mai		Will
/lan	uld be Menta Irked Itic ev	To B	Clifford Barrett					Ka	thleen	Fergu	son	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then. Insturet, or Items 23e or 28e-f show entry or other treumatic event, the Marical Examinat must be notified at once.		19a. Informant's Name/Relationship (Ty								ity or Town, State, Zi	p Code)
e,	1 and Health em 27 ther t		Myra L. Barrett/u	use	20b. P		5 Colora sition (Name of	7			21917 c. Location - City or T	own State
Baltimore,	ages ent of it: If it		1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	lemoval from State			sition (Name of natory or other place		10-26-2	2005		
aĦ	mit. F partme sorter y injur		21. Signature of Funeral Service License	9 7	100	22	. Name and Addre	ss of Facilit	R.T.	Foard 1	Colora, I Funeral Ho	малукана
<u>~</u>	permi Depa Impo eny ir		Kichard L.	you	que						Sun, MD	
١,			23a. Parl 1. Enter the diséase, or complishock, or heart failure. List only or	ications that caused ne cause on each lin	the death re.							Approximate Interval Between Onset and Death
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п	Examiner			Due to (or as	a conseq	uence or):						
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8760,	The law requires that the death certificate be executed ste has been signed by the attending physician and page 2 should be detached for use as the burial-transit	cai E		000 10 (01 00)	u 0011304	uonos on).						
89	tificate ng phy as the											
Вох	leath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1 ☐ Live birth	2 Feta	Ideath 3	Ectopic pregnancy	/			23d. Date of deliving	rery Day Year
O.	the al	Physician/Med	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at 9☐ Unknown	time of d	eath 5□	Other (specify) _				Wildital	Day 1 Sal
σ.	res that the de igned by the be detached	by Ph	Part II. Other significant conditions cor	ntributing to death be	ut not res	ulting in the u	nderlying cause giv	en in Part I.		23e. Did tobac	co use contribute to	the cause of death?
rds	w requires been sign should be		COPD.							1 🗆 Yes	2 □ No 3 □ Pro	bably 4 Unknown
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o	Attending Phyeiclen: The Ir death. ector: After this certificete haby the funeral director, page	n: To	27. Manner of Death	28a. Date of Injur (Month, Day		28b. Time of		y at			e 6 □Other (Speci injury occurred	'y)
Sior	ttendin death. stor: Aft the fun	atio	Natural 5 Pending investigation	(Month, Da)	rear)	Injury		Yes 2 🗆 I	No			
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	To the Hospitel within 24 hours a To the Funerel I completely filled		29a. Certifier Certifying Phys	sician: To the best of	of my kno	wledge, death	occurred at the tin	ne, date an	d place, and d	lue to the caus	e(s) and manner as	stated.
	To the Hospite within 24 hours To the Funerel completely filled	Medical	(Check only 2 Medical Examile one)	ner: On the basis of and manner sta	examina	tion and/or in	estigation, in my o	pinion, dea	th occurred at	the time, date	and place, and due	to the cause(s)
	To To I	Σ	29b. Signature and title of certifier		1	1	29c. Licens	e number	200	29d.	Date signed (Month,	Day, Year)
	TIM	1	/ Konso	/ Dianes	100	MI	1	428	UU		10/24/95	
	571		30. Name and address of person who ca	inpleted cause of d	eath (Item 7	3) (Type,	SOUTH 1	Model	MIC	416	100 210	78.
	Sta	te	31. Date filed (Monto Day, Yar)4 2	JUD 32. Pogistra	ar's Signa	tuck A	racks	-1000	1102/	140/	in the	,)
	Registr	aŗ		1		~ 17						

			1 - For State Registrar	State of	f Marylar				ealth a	and M	lental Hy	giene	l lan		35822	>
	Physici	an	Decedent's Name (First, Middle SANDRA	, Last) LYNN	BENNE	יווידן					2. Date of De Month	Day		ear	3. Time of Deal	
	/Medic Examin		4a. Facility Name (If not institution,			<u> </u>	4b. City,	Town, or	Location of	of Death	OCTOBE		County of	Death	07:40	М
	LXaiiii	iei	Casey House-600			l Rd.		Rocl	kvill	е			Mon	tgom	ery	
	Funeral Director		5. Social Security Number 214-48-8695 Usual Residence of Decedent	6. Sex 1 □ M 2 🗷 F	7. Age (In yrs. 58	last birthday) Yrs.	If Unde Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Sept.	y, Year)	947	Birthp Coun Ma	lace (State or For try) ryland	еign
	yland		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							1	0d. Inside City Lin	mits
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	with th	Funeral Director	10e. Street and Number 3000 Findley Ro	ad			10f. Zip	Code	2089	5			izen of Wh		,	
	death ms 23	erai	11. Marital Status	12. Was Dece	dent Ever in U	J.S. 13.	Was Dece	dent of Hi	spanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)		ited :			
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Baltimore, Maryland	nd 2 sho lth and 1 27 ie ma trauma		19a. Informant's Name/Relationsh Barbara A. Wise		:						I Route Numb				Code) Va.2340	01
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ţ	tment tant: I		4 □Donation 5 □ Other (Sp	ecify)		rklawn			- 1	-	6/05		ckvil	le,	Md.	
Bai	permit Depar Impor eny in		21. Signature of Funeral Service L	Licensee S	arhe	22	Muri P. C	el H	s of Facilit Bar ox 50	ber 38,	Funeral Laytons	l Hor	ne Le, M	d.	20882	
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	Pnysician /Medical		disease or condition resulting in death)	- W	etastat or as a consec	ic Lunquence of):	g Can	cer								
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Records,	law requires that the as been signed by th 2 should be deteche	ed by									1 🗆 '	Yes 2[⊒No 3	☐ Proba	ably 4 🖾 Únkno	nwo
eco	e lawre has bee je 2 sho	Completed									24a. Was		24b. We	re autop	osy findings availa	able of
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sior	Attending r death. ector: After by the funer	catio	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n	ation	, Day 76ai)	injury	М		r Yes 2 □ l	No						
Division	i Diffic	Certification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place	of Injury - At h ng, etc. <i>(Speci</i>	ome, farm, str fy)	eet, factor	y, office		2	28f. Location (: City or Tou	Street and wn, State	d Number)	or Rurai	Route Number,	
	e Hospitei 24 hours a 16 Funersi detely filled	edicai	29a Certifier 1 Certifyin (Check only 2 Medical E	Physician: To the examiner: On the ba and many	isis of examina	wladge deal ation and/or in	vestigation	at the tim , in my op	e, data an inion, deal	d place, t	and due to the ed at the time,	date and	and menn place, and	or as sti due to	the cause(s)	1.5
	To the within 2 To the comple	Me	29b. Signature and title of certifier	111			29	c. License	number	\ 1	0	29d. Dat	e signed (/	Month, L	Day, Year)	
)	10		Mos	Ill				00	11.	11	8	Oc	tobe	22	, 2005	
		1	30. Name and address of person v Charles Harris		e of death (Ite	m 23a) (Туре, 1 Munc a	Print) aster	Mil:	l Roa	d, R	ockvill	e, M	id. 2	2085	5	
	Sta	te	31. Date filed (Month, Day, Year)		egistrar's Sign	ature									***	
	Registr		OCT 2 4	2005	ues B	C SON	and the									

State of Maryland / Department of Health and Mental Hygie Pen 05 Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day Year **Physician** Dorothy a 19, Brown October 2005 2:40 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 3112 Gracefield Road, PV-116 Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. Min. Months Days Hours Min. August 28, 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 218 F 86 Yrs. 579-01-6195 1919 North Carolina Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits show me 23a or 28a-f short 1 Yes & No Director Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3112 Gracefield Road, PV-116 20904 USA Funeral (teme Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. the Medical Examiner filed within 72 hours after 1 □ Yes 2√□ No If Yes, Give Year or Dates: 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 Divorced 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Department of Heelth and Mental Hygiene. Important: it item 27 ie marked other than "ni any injury of other traumatic event, the Median once. Elementary/Secondary (0-12) College (1-4or 5+) 2 Secretary to Manager Telephone Company 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Otho R. Davidson Boyd Irene Absher ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3112 Gracefield Road, PV-116, Silver Spring, MD 20904 William C. Brown/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition October 22 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2005 Suitland, Maryland 21. Signatury of Puneral Service Licenses Francis J. Collins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Myocardial Infarction disease or condition resulting in death) Hours /Medical Due to (or as a consequence of) **Examiner** Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed nding physicien and use as the burial-transit Hypertension that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Completed by Physician/Medical Hypercholesterolemia use as IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 ☐ Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Atrial Fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 1☐ Yes 2**X** No 1 Tyes 2□ No Division of Vital To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) 1 🗌 Yes ို 2**√** No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 T Natural 5 Pending investigation To the nover seller death.

You the Funerel Director: At To the Funerel Director: At the funerel in by the funerely selled in by the funerely selled in by the funerely selled in by the funerely selled in by the funerely selled in by the funerely selled in by the funerely selled in by the funerely selled in by the funerely selled in by the funerely selled in by the funerely selled in by the funerely selled in t death. t ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D34590 October 20, 2005 ney MI

State Registrar Roy Fried, M.D.

31. Date filed (Month, Day, Year) 32. Registrar's Signature OCT 2 1 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3110 Gracefield Road, Silver Spring, MD 20904

			1 - For Stete Registrer	State of Ma	ryland / Dep <i>Ce</i>	ertificate of	lealth and	d Mental H	ygiene Reg. No.		35824
	Physici	an	1. Decedent's Name (First, Middle, Last)	-				2. Date of D	eath Day		3. Time of Death
	/Medic		Beverly Ann Benne					Octobe	er 1	9 2005	4:49 A M
	Examir	ier	4a. Facility Name (If not institution, give s	street and number)		4b. City, Town,		eath		County of Death	
	Funeral		15 Misty Lane 5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday	Port D	If Under 24 l	Hrs. 8. Date of B	irth	Cecil 9. Birthi	place (State or Foreign
	Director		212-38-4548	IM 2 X) F	65 Yrs.	Months Days	Hours N	Min. (Month, L. May 20	6,194	0 Coui	MD
	p >		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	continu					10d. Inside City Limits
	Aaryla r shor	ō									1 ☐ Yes 2X No
	28a-	rect	MD Cecil 10e, Street and Number		Port Do	10f. Zip Code	-		10g. Citi	zen of What Cou	ntrv?
	h with	Ö	15 Misty Lane			2190	4			SA	
	ems ?	ner		12. Was Decedent 8 Armed Forces?	ever in U.S. 13	. Was Decedent of If Yes, specify Cub		(Specify Yes or Nuerto Rican, etc.)		14. Race - Americ Black, White,	
36	s afte	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Microport	1 ☐ Yes 2 1 N If Yes, Give	0	1 ☐ Yes 2 ☐ XNo		, ,		Specity: Whi	
8	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Items 23a or 28a-f show other than "natural", or Items 23a or 28a-f show event, the Madical Examinational be notified at		15. Decedent's Edu	Year or Dates:	16a, Dec	edent's Usual Occu	pation		16b Ki	nd of Business/In	dustry
212	hin 72	Completed	(Specify only highest grade	College (1-4or 5	(Giv	e kind of work done DO NOT use retire	during most of	working			,
2	ed will ygien yer tha	Соп	12		Mana	iger				armacy	
Maryland 21215-0036	9 m 9	Be	17. Father's Name (First, Middle, Last)					Name (First, Middl	e, Maiden	Sumame)	
Ž	es 1 and 2 should b of Health and Ment I Item 27 is marked r other traumatic e	ဥ	George Jones 19a. Informant's Name/Relationship (Ty	ne Print)	19h Mai	ling Address (Street		Cully Bual Boute Num	her City o	r Town State Zir	Code)
	and 2 sho ealth and n 27 is mu		Terry Bennett/s			ine Cone					
Jre,	of Height Item		20a. Method of Disposition		20b. Place of Disp cemetery, cri	osition (Name of ematory or other pla		Date		cation - City or To	
<u><u>E</u></u>	Pages ment of ant: If its ury or o		1 X Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Harkord N	lemorial (Gardens	-22-2005	Abe	rdeen, M	D
Baltimore,	permit. Pages : Department of H Important: If ite any injury or ot once.		21. Signature of Funeral Service License	P Goo.	fie	22. Name and Address	ess of Facility 1 Queen Si	R.T. Foar treet, Ri	d Fur	reral Hor Sun, MV	me, P.A. 21911
			23a. Parl1. Enter the diseare, or compli shock, or heart failure. List only or	cations that caus of	the death. Do not e	nter the mode of dy	ng, such as care	diac or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	Apre	NOX C	ancinom	9				Onset and Death
	/Medical Examiner		1	Due to (or as a	consequence of):						,
	-	ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		consequence of):						
	be executed sician and burial-transit	Examiner	that initiated events								
, 0	cate be executed physician and the burial-transil		resulting in death) Last	Due to (or as a	consequence of):						
8760,	cate phys	dical								-	
9 xc	the death certifi y the attending tched for use as	O I	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome						23d. Date of delive	an/
. Box	death e atte	Physician/M	in the past 12 months?	1 Live birth 4 Pregnant at		□Ectopic pregnand □ Other <i>(specify)</i> _	у		₩.	Month	Day Year
P.0	at the de by the a tached	hys	9 🗆 Unknown	9□ Unknown	-						
	The law requires that tte has been signed b age 2 should be deta	by	Part II. Other significant conditions cor	tributing to death bu	it not resulting in the	underlying cause gr	ven in Part I.		tobacco u Yes 2[ne cause of death?
Vital Records,	w requir been si should	Completed	- TORSIGN					-			
Rec	The law ate has page 2 s	mpl						24a. Wa auto pen	opsy formed?_	prior to condeath?	psy findings available mpletion of cause of
ta		e Co	25. Was case referred to medical				26 Place of I	1 ☐ Yes Death Check only	2 No	1 🗆 Yes	2□ No
ί	nysic iis ce direc	To B	examiner?	ospital: 1 🗌 Inpatie	nt 2 ER/Outpatie	ent 3 DOA Ot	205	g Home 5 Res		G ☐ Other (Specifi	y)
n of			27. Manner of Death 1 □ Matural 5 □ Pending	28a. Date of Injur (Month, Day	y 28b. Time Year) Injury	of 28c. Inju	ry at rk?	28d. Describe	how injury	occurred	
Sio	Attending r death. ector: After by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be	On Bloom of Lain	- 44 (Yes 2 □ No	004 1	(0)	(4)	
Division	after death after death Director: d in by the	Certification;	4 Homicide determined	building, etc	ry - At home, farm, s . (Specify)	treet, factory, office		City or To	(Street and own, State)	d Number or Rura	i Houte Number,
	To the Hospital or within 24 hours after To the Funeral Dire completely filled in b	Medical C	29a. Certifier (Check only one) 1 Certifying Phys	sician: To the best of her: On the basis of and manner sta	f my knowledge, dea examination and/or i	th occurred at the ti	me, date and plants	ace, and due to the courred at the time	cause(s) , date and	and manner as st place, and due to	ated. the cause(s)
	ro the	Me	29b. Signature and title of certifier			29c. Licen:	se number		29d. Date	e signed (Month,	Day, Year)
			Danks K W	ledy >	Cons	Do	04437	3	10	20/200	5
	6		30. Name and address of person who co	mpleted cause of de	eath (Item 23a) (Type			veidner,	Jr. N	1D	
				Rising Su							
	Sta Registr	_	OCT 2 1 2005	32. Registra	r's Signature						

		For State Registrar	State of Maryland	/ Depar	tment of H	ealth a Death	and Men		igne ()	5	35825
1 1 1 1 1 1 No.	Ž	Decedent's Name (First, Middle, Last)					2. [Date of Deat	h		3. Time of Death
Physicia /Medic		Joyce Ann C	ornish				0	Month tober	Day 20	Jon 5	1045 M
Examin		4a. Facility Name (If not institution, give s	reet and number)		4b. City, Town, or	Location o	of Death			ty of Death	•
		PENIASULA REGIONAL	Medical Conta	2/	54	14354	1/4			11000	
Funeral Director		5. Social Security Number 6. Sex 215-38-2279	7. Age (In yrs. last		If Under 1 Year Months Days	If Under: Hours	Min. Ma	Date of Birth Month, Day, Y3	942	Cor	place (State or Foreign intry) Yland
p ,		Usual Residence of Decedent	100 Cib. T	own or Loca	11111						10d Incid Cit II in
anyla •hov	5	10a. State 10b. County	,								10d. Inside City Limits 1 ☐ Yes 🏋 No
the M	Directo	Maryland Wicomi 10e. Street and Number	co Q	uant	1 CO			1	0g. Citizen of	What Cou	
death with the Maryland me 23e or 28e-f ehow rmust be nutified at		22147 Rôyal Oak	Road		218	56			U.S.A		
death	Funeral		Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of Hi Yes, specify Cuba		gin? (Specify	Yes or No-	14. Ra	ce - Amer	ican Indian,
or its		1 Never Married 2 ☐ Marned	1 ☐ Yes 2 No	1	Yes 2 No	Specify:		11, 610.)	Speci	ack, White	
hours after tural, or its	d by	3 Widowed 4 Divorced	Year or Dates:							BT	ack
within 72 one. Then "nat	Completed	15. Decedent's Educ (Specify only highest grade	completed)	Give ki Give ki Iife. D	nt's Usual Occupa nd of work done d O NOT use retired,	ition <i>luring</i> most)	t of working		16b. Kind of E	dusiness/l	ndustry
r the	шо	Elementary/Secondary (0-12)	College (1-4or 5+)		estic				None	9	
ANG ZIZID-UUSD de filed within 72 hours after death with the Marylan anial Hygiene. sed other then "natural", or iteme 23e or 28e-f ehow cevent. The Medical Exeminer must be notified at	Be C	17. Father's Name (First, Middle, Last)				18. Mothe	er's Name (Fir	st, Middle, I	Maiden Suma	me)	
should b nd Ments marked umatic e	2	James Cornish			.	El	la Hu	11			
C1 40 72 40		19a. Informant's Name/Relationship (Typ		•	Address (Street a				,		,
re, N s 1 and f Health item 27 other ti		Marcie C.Jones (20a. Method of Disposition			Royal	Oak	Rd.Qu		20c, Md .		
Pages nent of h		1 Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	etery, crema	tory or other place	.		- 1			
		4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service License			etery Name and Addres		0-25-		Quanti	lco,	Ma.
permit. Depertition of the portion o		Head By	townst	1000	Name and Addres Lewart 21 West		ral H Salis		Md 21	1801	
* 700		23a. Part1. Enter the Isease, or complice shock, or hear failure. List only on	cations that caused the death.			Age agreement of the Control of the Control					Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Cause on each line.	- 6 ' 6							Onset and Death
/Medical		resulting in death)	Due to (or as a consequer	nce of):							
Examiner	_	Sequentially fist conditions, b			10ste	Cocc	zunis				
pe #st	ulue	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen	ice of):	1						
al-trar	Examine	that initiated events c. resulting in death) Last	Due to (or as a consequen	nce o'):	N a Way					-	
cate be executed cate be executed physicien and the burial-transit	dical	L.									
Certificat certificat nding phy	Medi	IE EELAN E									
that the death certificated by the attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	lc. If yes, outcome of pregnancy 1 Live birth 2 Fetal de	y eath 3□E	ctopic pregnancy					ate of deliv	ery Day Year
be death the attention the death of the attention the attention the attention to the attent	/sici	1 Yes 2 No	4☐ Pregnant at time of deat 9☐ Unknown	h 5□(Other (specify)				l M	Onti	Day real
ords, F.C. requires that the een signed by the hould be detached.	Ph	Part II. Other significant conditions con	tributing to death but not resulting	ng in the unc	leriving cause give	n in Part I.		23e. Did tol	acco use cor	ntribute to	the cause of death?
8 P 8	d by	- Co >			, , , , , , , , , , , , , , , , , , , ,			1 □ Ye	s 2 DHO	3 ☐ Pro	bably 4 Unknown
	lete	- G	T 41.					24a. Wasa	n 24b.	Were aut	opsy findings available
	Completed		- Siewi					autops perforr	ned?	prior to co death?	ompletion of cause of
VITAL sician: 1 certifical rector, p	a	25. Was case referred to medical				26. Place	of Death (Ch		e)	1 🗆 Yes	2 LJ NO
Or VITA Physician: rthis certific ral director,	ToB	examiner? 1 Yes 2 No	ospital: 1 Impatient 2 ER	VOutpatient	3□ DOA Cthe	9r: 4 □ Nu	irsing Home	5 🗆 Reside	nce 6 □Ot	her (Spec	fy)
tending Physideath.		27. Manner of Death 1 □ Matural 5 □ Pending	28a. Date of Injury (Month, Day Year)	3b. Time of Injury	28c. Injury Work			Describe ho	w infury occu	rred	
ISIO Ntendi death. ctor: A y the fu	cati	2 Accident investigation 3 Suicide 6 Could not be	70. 71.			/es 2 □ I		1 1 (0)			10 11
DIVISION I or Attending after death. Director: After	Certification:	4 Homicide determined	28e. Pface of Injury - At home building, etc. (Specify)	e, tarm, stree	et, factory, office			City or Towr		iber or Kui	al Route Number,
UNVISION To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune		29a. Certifier 1 Certifying Phys	ician: To the best of my knowle	edge, death	occurred at the tim	ie, date an	id place, and	due to the ca	ause(s) and m	anner as	stated.
he Hc in 24 I he Fu pletely	edical	(Check only 2 Medical Examinone)	er: On the basis of examination and manner stated.	and/or inve	stigation, in my op	oinion, dea	th occurred a	t the time, d	ate and place	, and due	to the cause(s)
With To t	≥	29b. Signature and title of certifier			29c. License			2	9d. Date sign	ed (Month	Day, Year)
S		KULD			Hoo	5615	7		10/20	105	
ا گی		30. Name and address of person who co	mpleted cause of death (ftem 23	3a) (Type, P	rint)	2 5		Is			
Sta	to	31. Date filed (Month, Day, Year)	32. Bigistrar's Signatur	Υ <u>}</u>	sente of	+ >	W13 6	7 145	218	7	
Sta Registr		31. Date filed (Month Cay Year) OCT 2 4 20	05 Strewe to	1. Sa	arti						

215-38-2279

341VA

Box 68760.

P.O.

29b. Signature and title of certific

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

DHMH 17 Rev 1/2001

ARD

AVE

			1 - For State Registrar	State of Ma	ryland / Depa <i>Cer</i>	artment of H tificate of L	ealth and Death		gie 2 0 0 5	35827
	Physicia	an	Decedent's Name (First, Middle, Last) Nicodemus	lami nas		~		2. Date of Dea Month	Day Ye	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give s	amirez		Gruz 4b. City, Town, or	Location of Dea	October 1	4c. County of (11:30 P M
	Examin	er	7037 Heather Drive	,		Bryans Ro			Charle	
	Funeral Director		5. Social Security Number 6. Sex 212–49–9458	M 2□F	(In yrs. last birthday) 52 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		7, Year) 9. 1953	Birthplace (State or Foreign Country) Philippines
	put &		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Maryla f sho	or	Maryland Charles		Bryans 1					1 □Yes XX No
	r 28a-	rect	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	t Country?
	th with	aiD	7037 Heather Drive			20616			USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel', or Itame 23a or 28a-f show amy injury or other treumatic event, I're Madical Exacilirat main be notified at anone.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ② N If Yes, Give Year or Dates:	lo	Was Decedent of Hi f Yes, specify Cuba 1 □ Yes 2 XXNo	ispanic Origin? (n, Mexican, Pue Specify:	(Specify Yes or No- erto Rican, etc.)	Black, \	American Indian, White, etc. Filipino
21215-0036	72 hou	Completed	15. Decedent's Educ (Specify only highest grade		(Give	lent's Usual Occupa	durina most of w	rorking	16b. Kind of Busin	ess/Industry
121	within lene. than "	mple	Elementary/Secondary (0-12)	College (1-4or 5	+) life.	City Carı	•		U.S. Post	al Service
0 0	filed v Hygie other t	o Co	17. Father's Name (First, Middle, Last)	years		arcy carr		ame (First, Middle,		di bervice
<u>lan</u>	Aental Aental rked c	To Be	Leon Cruz				Avelina	a Ramirez		
Maryland	2 should be f n and Mental H ls marked of reumatic eve		19a. Informant's Name/Relationship (Typ	pe, Print)					r, City or Town, Sta	te, Zip Code)
e, r	1 and Health em 27 ther t	1 9	Iordanka Cruz / Wife 20a. Method of Disposition		20b. Place of Dispo	sition (Name of		Road Mary 1	and 20616 20c. Location - Cit	y or Town, State
nor	Pages nent of I ant: If its ury or o		1XXBurial 2 ☐ Cremation 3 ☐ Re * 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Resurrection	natory or other place on Cemetery	Oct.	22, 2005	Clinton, M	
Baltimore,	permit. P Departme Importan any injur		21. Signatur Funeral Service License	lo b	۷ 22	Name and Addres	ss of Facility G	eorge P. Ka Oxon Hill,	las Funeral	•
			23a. Part1. Enter the disease, or complishook, or heart failure. List only on	cations that caused	the death. Do not ent					Approximate Interval Between
2	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	l	LUNG, a consequence of):	CAN				Onset and Death
8760,	cate be executed physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to initiodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Suarto (or en	a consequence of):					
.O. Box 68	death certifi e attending I id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	Ectopic pregnancy			23d. Date o Month	f delivery Day Year
s, P	es pe pe	ρ	Part II. Other significant conditions con		ut not resulting in the u	nderlying cause give	en in Part I.			te to the cause of death? Probably 4 Unknown
Vital Record	e law has b	Completed						24a. Was a autop perfor 1 Yes	sy prio med? dea:	e autopsy findings available r to completion of cause of th? Yes 2 \(\sum \) No
/ita	sicien: Th certificete rector, pag	Be (25. Was case referred to medical examiner?	leanital:		Cth		eath (Check only o	ne)	
ō	lys dills	tion: To	1 Yes No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 _ Inpatie 28a. Date of Injui (Month, Day		f 28c. Injun Worl	4 Nursing		dence 6 Other (Specify)
Division	iel or Attending PP s after death. 91 Director: After the ed in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc.	ury - At home, farm, sti c. (Specify)	reet, factory, office		28f. Location (S City or Tow		or Rural Route Number,
	To the Hospitel or Atter within 24 hours after de To the Funerel Directo completely filled in by th	edical			of my knowledge, deat examination and/or in ited.	vestigation, in my o	pinion, death oc	curred at the time,	date and place, and	due to the cause(s)
4	To the To the comp	ž	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed (A	fonth, Day, Year)
			Alle	M		ע ש	3883		10-0	- 2005
	(5)		30. Name and address of person pro co	and MDS	eath (Item 23a) (Type,	FACE Ro	A9 # 3	BUY WAY	over M	D 20602
	Sta Regist		31. Date filed (Month, Day, Year) OCT 2 4 2005	2. Registra	ar's Signature					

l	Claure State of Ma	aryland / Dep	artment of Hea	aith and Mental Hy	/giemen n =	35828
	1 - Stete Ragistrar		ertificate of De		Rag. No.	33020
١	Decedent's Name (First, Middle, Last)			2. Date of De Month	eath Day Year	3. Time of Death
	Jaime J. Claure			Octobe		13:25 P [™]
	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Lo	cation of Death	4c. County of Dea	th
	Interstate 95 N. Mile Mark	er 23.63	Greenbelt		Prince Ge	eorge's
	5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday		Under 24 Hrs. 8. Date of Bi	irth 9. Bir ay, Year) Co	thplace (State or Foreign puntry)
	214-29-5022	46 Yrs.		Hours Min. 08/07/	1959 Bol	ivia
	Usual Residence of Decedent	140 00 7				Table to the state of the state
	10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
	Virginia Fairfax	Falls Ch	urch			1 X Yes 2 □ No
	10e. Street and Number		10f. Zip Code		10g. Citizen of What Co	ountry?
1	3611 Malibu Circle #110		22041		Bolivia	
	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hisparity Cuban.	anic Origin? (Specify Yes or N Mexican, Puerto Rican, etc.)	o- 14. Race - Ame Black, Whit	
3	1 Never Married 2 Married 1 Yes 2 If Yes, Give			Specify:		
	3 ☐ Widowed 4 🛣 Divorced Year or Dates:		121103 2010	Bolivian	Specify: W	hite
	15. Decedent's Education (Specify only highest grade completed)	(Giv	edent's Usual Occupation e kind of work done during DO NOT use retired)	n ing most of working	16b. Kind of Business	/Industry
	Elementary/Secondary (0-12) College (1-4or : 3	5+)	nanic		Auto	
)	17. Father's Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·	18	B. Mother's Name (First, Middle	e, Maiden Sumame)	
2	Juan Claure			Carmen Galdo		
	19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ling Address (Street and	Number or Rural Route Numb	ber, City or Town, State,	Zip Code)
	Carmen Claure/ Sister	4403	31 Laceyvil	le Terrace Ash	burn, VA 20	147
	20a. Method of Disposition	20b. Place of Disp	position (Name of	Date	20c. Location - City or	Town, State
	1 XBurial 2 □ Cremation 3 XRemoval from State 4 □ Donation 5 □ Other (Specify)	Parque	ematory ocother place) e de Las norias	unk.	Cocha Bamb	a, Bolivia
	21. Signature of Funeral Service Licensee	2	22. Name and Address	of Facility Robert E.	Evans Fune	ral Home
) Kalan		16000 Anna	polis Road Bow	ie, MD 2071	5
	23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each li	d the death. Do not er	nter the mode of dying,	such as cardiac or respiratory	arrest,	Approximate Interval Between
	Immediate Cause (Final	un Lala	T			Onset and Death
	disease or condition resulting in death)	a consequence of):	- ryu	14/)		
	Due to (or as	a consequence or):	U			

Physician /Medical Examiner

use as the burial-transit

signed by the attending physicien and d be detached for use as the burial-trar

been si

within 24 hours after use....

To the Funeral Director: After this

ö

Be

Certification: To

Medical

State Registrar

Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

permit. Page Department of Importent: if any injury or once.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that initiated events resulting in death) Last Completed by Physician/Medical

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death

Due to (or as a consequence of):

Due to (or as a consequence of):

4☐Pregnant at time of death 9☐ Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 2 70

3 Probably 4 □Unknown

Year

24a. Was an autopsy performed? 10 Yes 2 No 26. Place of Death (Check only one)

25. Was case referred to medical examiner? 1 XYes 2 No 27. Manner of Death

1 Natural

29a. Certifier

23b. Was decedent pregnant in the past 12 months?

9 Unknown

1 Inpatient 2 ER/Outpatient 3 DOA 5 Pending 10/18/05

28b. Time of Injury :24 PM

(n)

28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred

2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

marker 23:63.

29b. Signature and title of certifier

29c. License number OCME

October 19, 2005

30. Name and address of person who completed cause of death (Item 23a) Type, Print) 111 Penn Street

31. Date filed (Month, Day, Year)

OCT 2 4 2005

32. Registrar's Signature

DHMH 17 Rev 1/2001

Other: 4 Nursing Home 5 Residence 6 Other (Specify) Scene

24b. Were autopsy findings available prior to completion of cause of death?

1 △ Yes 2 □ No

Driver in a wotor

Driver in a wotor

Vehicle accident

281. Location (Street and Number or Rural Route Number,

City or Town, State) I 95 N (2 Www.)

N. @ muli Greenbeet, WIL 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21201

			State Unpend Item 23a, p	e of Maryland t.II,27,28	d / Depa Ba-f _{Ce}	artment of F er me G84 tificate of	lealth and M 9 11–22–0 Death	lental Hygi 5 tas	e2e005	35829
()	Physici	an	1. Decedent's Name (First, Middle, Last) Linda Lee Cook					2. Date of Death OCTOBER	^D 29,2005	3. Time of Death 10:46A. M
	/Medic Examin		4a. Facility Name (If not institution, give street at CALVERT MEMORIAL HOSP				r Location of Death		4c. County of Death	10.1011
2640	Funeral Director		5. Social Security Number 212-66-2639 Usual Residence of Decedent	7. Age (In yrs. I.	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, eb. 5,	Year) Cou	place (State or Foreign ntry) nington DC
	the Maryland 28a-f ehow notified at	ector	10a. State 10b. County Maryland Calvert 10e. Street and Number		, Town or Lo	e Beach		10	g. Citizen of What Cou	10d. Inside City Limits 10d. Inside City Limits 10d. Inside City Limits
	3a or 2	I Dir	3731 28th Street			2073	32	10	USA	nuyr
920	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or Iteme 23s or 28s-f show other traumatic svent, the Madical Examinar must be nutified at	by Funeral Director	1 Never Married 2 Married 1 If Ye	Decedent Ever in U.sed Forces? Yes 21 No s, Give r or Dates:		Was Decedent of H f Yes, specify Cub	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify: Wh	
Maryland 21215-0036	ithin 72 ho ie. ien "naturi Medical I	Completed		eted) ege (1-4or 5+)	(Give lite.	DO NOT use retire	during most of worki	ing	6b. Kind of Business/Ir	
121	Hygien Hygien ther th	Con	12 17. Father's Name (First, Middle, Last)		Secr	etary	18. Mother's Name		<mark>lerchant Ma</mark> aiden Sumame)	rines
and	lid be flental l	To Be	Harry Kenneth Farmer					eth Ann W		
Mary	d 2 shouth and M		19a. Informant's Name/Relationship (Type, Prin. Michael Cook - Husband	•					City or Town, State, Zi	
	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra ance.		20a. Method of Disposition 1 🛱 Burial 2 □ Cremation 3 □ Removal	20b. P	lace of Dispo emetery, crea	sition (Name of matory or other pla	ce)	Date 2	Oc. Location - City or T	own, State
Baltimore,	nit. Pag antment ortant: injury e		4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee			Memorial . Name and Addre		9-2005 W P. O. E	Maldorf, MD	
Ba	Depa Impo any i		Nack A Willyn)	Н	untt Fune	eral Home		, MD 20604	-0156
8760,	Physician and American and American and Inc. (1997) American and Inc. (dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ue to (or as a consequent to (or as a consequ	uence of):	cated by	cocaine i	ntoxicat	ion	Onset and Death
P.O. Box 68	Attending Physician: The law requires that the death certifica (death) of death certifica setor: After this certificale has been signed by the attending phy the funeral director, page 2 should be detached for use as the	Completed by Physician/Med	in the past 12 months?	es, outcome of pregna Live birth 2 ☐ Fetal Pregnant at time of de Unknown	death 3	Ectopic pregnanc Other (specify)	y		23d. Date of deliv Month	ery Day Year
rds, P	w requires that been signed t should be deta	ed by PI	Part II. Other significant conditions contributin	g to death but not resu	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did tob	acco use contribute to	the cause of death? bably 4 □Unknown
Division of Vital Records,	ysician: The law requisions that the continuity of the continuity of the contract of the contr	Complet						24a. Was an autopsy perform	ed? prior to co	opsy findings available ompletion of cause of
Vita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner? Hospital			Ott	26. Place of Death			
ion of	ath. ath. r: After this se funeral di	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Date of Injury	28b. Time o	f 28c. Inju	4 Nursing Ho	me 5 Resider 28d. Describe how	nce 6 Other (Speci w injury occurred	unk
Divis	in Diffe	Certification:	3 Suicide 6 Could not be 4 Homicide 28e.	Place of Injury - At he building, etc. (Specify ound at re	ome, farm, st y) sidenc	reet, factory, office		28f. Location <i>(Str. City or Town,</i> Chesapeak	eet and Number or Ru State) 3731 27 Le Beach, M	th St.
	Hospital 24 hours a Funeral I etely filled	Medical (29a. Certifier (Check only one) 1 Certifying Physician: 2 Medical Examiner: Or an							
	To the within 2 To the complet	Me	29b. Signature and life of confiler			29c. Licens	se number	29	d. Date signed (Month,	Day, Year)
			30. Name and address of person who complete	d cause of death (Item	1 23a) (Type.		.M.E.	OC	TOBER 30,20	005
	B		MARY G. RI	PLan		111 PENN	STREET B	ALTIMORE	MARYLAND 2	21201
1	Sta Regist		NOV 0 1 2005	32. Registrar's Signa	K A	me				

State of Maryland / Department of Health and Mental Hygiene 05 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) OCTOBER Year **Physician** 1355 an Haa Niana 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cecil enion Hospita Elkton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Months 1 □ M 2 💢 F 84 Vrs FEB. 28, 1921 CHINA Director 222-82-6618 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County event, the Medical Exeminer must be notified at 1XYes 2 No NEWARK DELAWARE Director NEW CASTLE 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number UNITED STATES OF AMERICA or Items 23a 42 HAWTHORNE AVE. 19711 by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ified within 72 hours after de I Hygiene. Other than "naturel", or Item 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ASIAN 3 ▼Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) **EDUCATION** 3 TEACHER marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental (UNKNOWN) CHANG (UNKNOWN) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health a 42 HAWTHORNE AVE., NEWARK, DE 19711 CHIANG MIIN WANG / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If eny injury or once. 10/28/2005 MAYERDALE CREMATORY NEWARK, DE 21. Signature of Funeral Service Licensee SPICER-MULLIKIN FUNERAL HOMES M00840 1000 N. DUPONT PKWY., NEW CASTLE, DE 19720 23a. Part1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** odroo crest /Medical Due to (or as a consequence of): Examiner 12 ST CONSEQUENCE OF Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Quality for physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Dav in the past 12 months?
1 Yes 24 No
9 Unknown 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ eq 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed page certificate 2K No 1 Tes 2 X No 1 Yes Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 2 Accident 5 Pending М 1 ☐ Yes 2 ☐ No death. investigation the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person wh empleted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 92. Registrar's Signature State OCT 2 5 2005 Registrar

			1 - For Stata Registrar	State of	Maryland / D	epartment o Certificate			Hygiene Reg. No.	105	35831
	Physicia	an	1. Decedent's Name (First, Middle, Last)		_			2. Date of Month		Year_	3. Time of Death
	/Medic	al	Betty Farver		lins	45 ON T-		0cto			10:35A M
	Examin	er	4a. Facility Name (If not institution, give s 890 Banner Ave.	treet and numb	er)		wn, or Location on Bride		4c. C	ounty of Death Carro	
	Funeral		Social Security Number 6. Sex		Age (In yrs. last birth	day) If Under 1	ear If Under		f Birth		place (State or Foreign
	Director		215-34-7418	M 2 1 F	77 Y	s. Months [ays Hours	Min. Sept	f Birth . 28, 192	28 Mar	y Yand
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits
	Maryl fish	ğ	Maryland Carrol	1		Union	Bridge				1 ☐ Yes 2 🛣 No
	r 28a	Directo	10e. Street and Number			10f. Zip Co			10g. Citize	on of What Cou	intry?
	th wit	ai D	890 Banner Ave.				217	791		U.S.A.	
	tems	Funerai		2. Was Decede Armed Force	es?	13. Was Deceder If Yes, specify	t of Hispanic Or Cuban, Mexica	igin? (Specify Yes on, Puerto Rican, etc	r No- 14	I. Race - Amer Black, White	
36	rs aft	by F	1 Never Married 2 Married 3	1 ☐ Yes 2 If Yes, Give Year or Date	ANO	1 ☐ Yes 2	No Specify	:	s	pecify:	White
ò	72 hours after death with the Maryland natural; or items 23e or 28e-f show disal Examination with beaudified at	ted	15. Decedent's Educ	ation	16a. [ecedent's Usual (16b. Kind	of Business/Ir	ndustry
215	within 7 ene. than r	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4		ife. DO NOT use	retired)	st of working		a. wa baw	
121	be filed within 72 hours after death with the Marylan ital Hygiene. od othar than natural; or items 23e or 28a-1 show event, the Madical Examination in the modified at		17. Father's Name (First, Middle, Last)			homer		er's Name (First, Mi		own hom	e
yland	2 should be f and Mental H is marked of raumatic eva	To Be	Leroy Oliver Farv	er			10. 1410(11	Ella Ma			
Baltimore, Maryland 21215-0036	ges 1 and 2 should it of Health and Men If itam 27 is marke or other traumatic		19a. Informant's Name/Relationship (Type Arnold Weeks Jr./			Mailing Address (S O Pin Oal		er or Rural Route N Gettysbu			p Code)
ore,	es 1 a of Hea fitam rothe		20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Re	amoval from Str	cemetery,	Disposition (Name crematory or othe	r place)	Date		ation - City or T	
ij	Pages Iment of I tant: If its jury or o		' 4 ☐ Donation 5 ☐ Other (Specify)		Mount	Pleasant		0/24/2005		ytown,	
Ball	permit. Page Department of Important: If any injury or		21. Signature of Fundaral Service License	. Xan	plen	6 E. Bro		^{ity} Hartzler Union Br			
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that cau e cause on eac	sed the death. Do no	t enter the mode o	f dying, such as	cardiac or respirato	ry arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)		Laver	Cire	was				2 year
	/Medical Examiner		1	Due to (or	as a consequence of):					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	as a consequence of):					
	cate be executed physician and the burial-transit	Examiner	that initiated events							- 1	
30,	oe exe		resulting in death) Last	Due to (or	as a consequence of):					
8760,	physic the b	dicai	d								
Box 6	death certific e attending p id for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23		me of pregnancy				23	d. Date of deliv	erv
	0 D	icia	in the past 12 months? 1 □ Yes 2 □ No	4□Pregnan	h 2 Fetal death it at time of death	3 ☐ Ectopic preg 5 ☐ Other (spec			_	Month	Day Year
P.0	at the de by the a	hys	9 🗆 Unknown	9□ Unknow				100	1		
	The law requires that the te has been signed by th bage 2 should be detache	b	Part II. Other significant conditions con		th but not resulting in (he underlying cau:	se given in Part		Did tobacco use	_	the cause of death?
Sor	w requir been si should	etec									
Vital Records,	The lav	Completed							utopsy performed?	prior to co death?	opsy findings available ompletion of cause of
tal		O	25. Was case referred to medical				26. Plac	1 ☐ Y e of Death (Check o		1 🗆 Yes	2 No
Ţ	di si	To B	examiner? 1 ☐ Yes 2 ☐ Ho	ospital: 1 🗌 Inp	atient 2 ER/Outp	atient 3 DOA	Other	ursing Home 5-1		☐Other (Speci	fy)
n of			27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of (Month,		ury	Injury at Work?		ibe how injury o	occurred	
Division	Attending r death. actor: After by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be	One Place of	Inium. At home form	M	1 □ Yes 2 □		on (Street and)	Alumbos os Ous	al Route Number,
Div	of or Attency after death Diractor:	Certification:	4 Homicide determined	building	Injury - At home, farn , etc. (Specify)	i, street, lactory, o	ilice		Town, State)	VUINDER OF MUI	ai Aoute Ivamber,
	urs urs ille	edical C	29a. Certifier 1 Cartifying Phys (Check only one) 2 Madical Examin	ician: To the bear: On the basi	est of my knowledge, is of examination and	death occurred at or investigation, in	he time, date ar my opinion, dea	nd place, and due to ath occurred at the ti	the cause(s) ar me, date and p	nd manner as s lace, and due t	stated. o the cause(s)
	To the Hosl within 24 ho To the Funs completely f	Me	29b. Signature and title of certifier	1		29c. L	icense number			signed (Month,	
	174		1	Im	m		D do	5643		W - 21	.05
	Wy		30. Name and address of person who co	mpleted cause	of death (Item 23a) (T	ype, Print)	reviras	Dr TA	rentou	+ , mp	६८४। ९
	Sta Registr		31. Date filed (Month, Day, Year)		Frar's Signature	down.	ş				

Certificate of Death

2. Date of Death

35832

3. Time of Death

State

Registrar

31. Date filed (Month, Day, Year)

OCT 24

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

32 Registrar's Signature

11011	y Chane	y -	State Unpend Item 23ad	ate of Maryland 227 per me G 8	/ Depa 50 _C 12	rtment of He tificate of E	ealth and M Death	lental Hygi	iene 005	35833
	Physici		Decedent's Name (First, Middle, Last)	_		-		2. Date of Death Month October	Day Year	3. Time of Death 12:20 P4
Ų.	/Medic	al	Anthony ta. Facility Name (If not institution, give stree	L.		Chaney 4b. City, Town, or	ocation of Death	october	4c. County of Dea	
	Examin	er	3030 Brinkley Road	_		**	e Hills		Prince Ge	
	Funeral Director		5. Social Security Number 6. Sex 1 🗵 M	7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 5,	Year) C	thplace (State or Foreign ountry) cyland
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, 1	Town or Lo	cation				10d. Inside City Limits
-	8a-f sho	ector	Maryland Prince George	's Ter	mple Hi				On Citizen of Miles C	1 ☐ Yes XXXNo
	with fl	Dir	10e. Street and Number 3030 Brinkley Road #T-	1		10f. Zip Code 20748			0g. Citizen of What C USA	ountry ?
36	72 hours after death with the Maryland natural', or Itama 23a or 28a-f show Jical Examinat must be notilliad at	by Funeral Director	11. Marital Status 12. Married 12. Married	Vas Decedent Ever in U.S. Immed Forces? XXYes 2 □ No f Yes, Give fear or Dates:		Vas Decedent of His Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	te, etc.
9-0	72 hours "natural", oldel Exc	tedt	15. Decedent's Education (Specify only highest grade co.	n .	16a. Deced	ent's Usual Occupa kind of work done d	tion uring most of work	ina	16b. Kind of Business	/Industry
2121	d within J jiene. rr then "r	Completed		College (1-4or 5+)	life. L	00 NOT use retired) inter			Private Indu	stry
and	12 should be filed within h and Mental Hygiene. 7 is marked other then "traumatic event, the Men	To Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam-		Maiden Sumame)	
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hc f of Health and Mental Hygiene. If Item 27 is marked other then "nature or other traumatic event, Its Madical		Augustus Chanev 19a Informant's Name/Relationship (Type, Lillian M. Sine / Sist			g Address (Street a			City or Town, State, d 20816	Zip Code)
	of Heali Item 2	1	20a. Method of Disposition	20b. Piac	e of Dispo	sition (Name of natory or other place	,	Date 2	20c. Location - City o	Town, State
Baltimore,	Page tment tant: If		12⊠Surial 2 □ Cremation 3 □ Remo 4 □ Donation 5 □ Other (Specify)	Mary]		eterans Cem.	11/03,	/2005	Cheltenham,	Maryland
Bal	permit. Pages 1 and 2 Department of Health s Importent: If Item 27 li any Injury or other tra 906e.		21. Signature of Funeral Service Licensee		61	. Name and Addres. .60 OxonHill	s of Facility Ge . Road Oxon	orge P. Ka Hill, Mar	las Funeral yland 20745	Home PA
nd nd	Physician /Medical Examiner	ner	shock, or heart failure. List onty one collimmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events co.	Atherosclerot Due to (or as a consequent	nce of):	rdiovascu	lar Dise	ase		Interval Between Onset and Death
68760,	The law requires that the death certificate be executed ate hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit	edical Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent	nce of):					
P.O. Box	it the death certific by the attending p tached for use as	Physician/M	in the past 12 months?	f yes, outcome of pregnanc 1 □Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	olivery Day Year
	quires that n signed b uld be def	þ	Part II. Other significant conditions contrib	uting to death but not resulti	ing in the u	nderlying cause give	n in Part I.	23e. Did tob	:/	robably 4 Unknown
Division of Vital Records,	ician: The law requir certificate hes been si ecfor, page 2 should	Completed							y prior to death?	utopsy findings available completion of cause of
₹	ysicial is certi directo	To Be	25. Was case referred to medical examiner? 1 X Yes 2 No Hosp	ital: 1 ☐ Inpatient 2 ☐ EF	R/Outpatien	t 3 DOA Othe	26. Place of Deat	me 5 ☐ Reside	*****	ecify) SCENE
on of	ding Ph I. After th funeral	tlon: T	La Transcription of the latest terms of the la		8b. Time of Injury	28c. Injury Work			w injury occurred	,
Divisi	or Attendi affer death. Director: A	Certification:	a Could not be	8e. Place of Injury - At hom building, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (St. City or Town	reet and Number or F n, State)	lural Route Number,
_	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Co		en: To the best of my knowl On the basis of examinatio and manner stated.						
	To the within 2 To the comple	Med	29b. Signature and title of certifier	- (No. 00 M	N	29c. License	number		9d. Date signed (Mor	
			30. Name and address of person who comp	eted cause of death (Item 2	23a) (Type, 111			1		
1	St	ite	31. Date filed (Month, Day, Year)	32. Paistrar's Signatu		1-5-				
	Regist	ar	NOV 0 4 200	5 Bleeve 1	K A	Section 1				

			1_ For State	State of Maryla				•	9	35834
			Registrar		Ce	rtificate of	Death		Reg. No.	
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Crace Do	linger				2. Date of E Month	Day Y	3. Time of Death ear 005 0740 A M
	Examir		4a. Facility Name (If not institution, give s	4 4 4 1	1	4b. City, Town, o	r Location of Dea	th	4c. County of	Death
S.		Mary Mary	Coastal Hospice		ake	Sal	Sbury		Wic	omico
-6	Funeral Director		5. Social Security Number 16. Sex	м 2 М F 77	rs. last birthday, Yrs.	Months Days	If Under 24 Hrs Hours Min	8. Date of B (Month, L 12/4/	Dav. Year)	9. Birthplace (State or Foreign Country)
			Usual Residence of Decedent					12/4/-	1921	New Jersey
	how		10a. State 10b. County		City, Town or L					10d. Inside City Limits
	Ba-1-s	cto	Maryland Wicomico	·	Parson	sburg				1 ☐ Yes 2 ☐ No
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 ie marked other than "natural", or Itema 23e or 28e-f show other traumatic event, the Madical Examiner must be notified at	Funeral Director	32784 Mt. hermon	Rd.		10f. Zip Code 2184	9		10g. Citizen of Wh USA	at Country?
	ema erm	ner	11. Marital Status	Was Decedent Ever in Armed Forces?	1 U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Specify Yes or No Rican, etc.)	lo- 14. Race -	American Indian, White, etc.
36	or It	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes Ž No	Specify:	,	Specify:	white
Ö	hour tural	pe pe	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:	163 Door	dent's Usual Occup	ation		10h Kind of Busi	
5	in 72 Ina	olet	(Specify only highest grade	completed)	(Give	kind of work done DO NOT use retired	during most of wo	rking	16b. Kind of Busi	ness/moustry
212	i tha	Completed	Elementary/Secondary (0-12)	Colfege (1-4or 5+)	Hou	sewife			Domest	ic
Maryland 21215-0036	ould be filed Mental Hygi arked other atic event, L	Be	17. Father's Name (First, Middle, Last) George Washington	Andrews			_		le, Maiden Sumame) ude Hutchi	
yla	should Ind Mening Marke	J.								
Mai	d 2 sho h and 7 le mu traum		19a. Informant's Name/Relationship (Type Bradley Dolinger/s	•					ber, City or Town, St	
	1 and 1 Health Iem 27		20a. Method of Disposition	-	. Place of Dispe	osition (Name of		Date	nsburg, MI 20c. Location - Ci	
5	ages of of t: If It		1 Surial 2 □ Cremation 3 □ Re		cemetery, cre	matory or other place t Cemeter	v 10/2	22/05	Salisbu	
Baltimore,	permit. Pages 1 and Department of Health Importent: If Item 27 any injury or other tr once.		4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service License					•		-
ä	Depar Impor		David 2. 1 Dans	MADON CF	SP 5	01 Snow H	Hill Rd.	, Salisk	oressional oury, MD 2	Association 1804
Alex			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on		eath. Do not en	ter the mode of dyin	ng, such as cardia	c or respiratory	arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Metasta	1. '		anen		Reco	Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):					
and the	Lxammer	L	Sequentially fist conditions, b.	2 - 1 - (0					
	led sit	ulue	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence or):					
	al-tra	Examiner	that initiated events c. resulting in death) Last	Due to (or as a cons	equence of):					
760	eath certificate be executed attending physician and for use as the burial-transit	calE	L _d							
99	tificat ig phy as the									
Вох	th cert endin	N/UE	230. Was decedent pregnant	c. If yes, outcome of pred 1 Live birth 2 □ F		∃Ectopic pregnancy	,		23d. Date of	,
	e deal	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐No 9 ☐ Unknown	4☐Pregnant at time of		Other (specify)	· 		Month	Day Year
P.0	that the de ted by the a detached f	Phy	Part II. Other significant conditions con-	tributing to death but not u	resulting in the u	nderlying cause giv	en in Part I	23e Did	tobacco use contribu	ute to the cause of death?
Vital Records,	8 5 0	d by		inibuting to doubt but not	oodiinig in the t	industy ing course giv	on arract.			☐ Probably 4 ☐Unknown
CO	w require been sig should b	lete						24a. Wa	s an 24h We	re autopsy findings available
Be	he lav e has age 2	Completed						aut	opsy prio formed? dea	or to completion of cause of the
ta		0	25. Was case referred to medical				26. Place of De	1 ☐ Yes ath Check only		Yes 2 No
Ž	Physician: this certific ral director,	To B	examiner?	ospital: 1 patient 2	☐ ER/Outpatie	nt 3 DOA Oth	or		sidence 6 Other	(Specify)
n of	ng Ph fter th neral		27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day Year,	28b. Time o	f 28c. Injur Wor			how injury occurred	
<u>S</u> i	ittendi death. ctor: A / the fu	catl	2 Accident investigation 3 Suicide 6 Could not be			M 1 🗆	Yes 2 □No			
Division	after d Direct In by	Certification;	4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, st ecify)	reet, factory, office		28f. Location City or To	(Street and Number own, State)	or Rural Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier Certifying Phys	ician: To the best of my b	nowledge, deat	h occurred at the tin	ne, date and plac	and due to the	e cause(s) and mann	er as stated.
	the Horizant 24 the Fu	Medical	one)	er: On the basis of exam and manner stated.	ination and/or in	vestigation, in my o	pinion, death occ	urred at the time	, date and place, and	d due to the cause(s)
	To To	2	29b. Signature and title of certifier	0(1)	M	29c. Licens	e number	70	29d. Date signed (/	Wonth, Day, Year)
•	S				1110	No	162	10	10 -	11-03
	B,		30. Name and address of person who con		tem 23a) (Type,	Print)	But	32	Solish	MM 71861
Today.	Sta	ite	31. Date filed (Month, Day, Year)	32. Ragistrar's Sig	nature	ILE / U	11 XW	- 5	1136	~ 10 M 0 ~ ~
14	Registr		OCT 2 1 20	05 Deserve	B. A	marke				

ary Ant 5-7033 KG	ho	ny Davis, Jr Please Type or Pri State of M	nt in Black In aryland / Dep			•	•	0000
		State Registrar		rtificate of		Reg	2005 j. No.	35835
Physici		Decedent's Name (First, Middle, Last) GARY ANTHONY D.	AVIS, JR			2. Date of Death October	16, 2005	3. Time of Death 12:20 P M
/Medic Examin		4a. Facility Name (If not institution, give street and number,		4b. City, Town,	or Location of Death		4c. County of Deat	h
Funeral		Shady Grove Adventist Ho 5. Social Security Number 6. Sex 7. A	spital ge (In yrs. last birthday)		If Under 24 Hrs.	8. Date of Birth	Montgome 9. Birth	ry hplace (State or Foreig
Director		215-92-8503 ** M 2 F	26 Yrs.	Months Days	Hours Min.	Feb. 18,	1979 °R	Maryland
72 hours after deeth with the Maryland natural; or Items 23a or 28a-f show itsal Examiner must be notitled at	Director	Usual Residence of Decedent 10a. State 10b. County MD Montgomery	10c. City, Town or Lo	ocation Germant	cown			10d. Inside City Limits
23a or 2 ust be no	ai Dire	10e. Street and Number 12916 Falling Water	Cir. #30	3 10f. Zip Code	20874	10g	U.S.A	•
al', or Items Examiner m	by Funerai	11. Marital Slatus 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Amed Forces 1 ☐ Yes 2 X If Yes, Give Year or Dates:	No	Was Decedent of If Yes, specify Cut	Hispanic Origin? (Spectan, Mexican, Puerto For Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: B 1 &	e, etc.
than "	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	(Give	DO NOT use retire	during most of working	ng	RSIS	Industry
C) @	To Be C	17. Father's Name (First, Middle, Last) Gary A. Davis, Sr.	4		18. Mother's Name Bre		an Pearso	on
Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event once.		19a. Informant's Name/Relationship (Type, Print) Gary S. Davis, Sr. (F 20a. Method of Disposition 1X Murial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Singular of Employee Lines e	ather) 1 20b. Place of Dispresentery, cre Gate of	.3043 We astion (Name of matory or other plate Heaver 2. Name and Addr		Ct., G ate 20 22/05 S WDEN FU	Germanton C. Location - City or Silver SI INERAL H	wn, MD Town, State Oring, MI OME, F.A.
nysician Medical xaminer	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	ine.	ter the mode of dy		r respiratory arrest	t,	Approximate Interval Belween Onset and Death
ed by the attending physicien a detached for use as the burial	Physician/Medical		2 Fetaf death 3	□Ectopic pregnand □ Other (specify) _	эу		23d. Date of deli Month	very Day Year
as been signed by 2 should be detac	ρ	Part II. Other significant conditions contributing to death	but not resulting in the u	underlying cause g	iven in Part 1.	23e. Did toba	cco use contribute to	The cause of death?
ate has	Completed					24a. Was an autopsy performe	prior to d	topsy findings availab completion of cause of 2 \square No
is certific director.	Be	25. Was case referred to medical examiner? Hospital:			26. Place of Death			
within 24 hours efter death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification: To	27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could mine be determined.	ury 28b. Time o	of 28c. Inju	ary at 2 page 2	8d. Describe how	et and Number or Ru State)	e collision
24 hours • Funera letely fills	edicai C	29a. Certifier (Check only one) 1 Certifying Physician: To the besise and manners and manners	of examination and/or in	th occurred at the to exestigation, in my	time, date and place, a opinion, death occurre	and due to the caused at the time, date	se(s) and manner as	stated.
To the comple	Me	29b. Signature and title of certifier Zelziuuar Al	2-	ļ II	se number		Date signed (Month	•
		30. Name and address of person who completed cause of ZARIUCIAH ALI	death (Item 23a) (Type	Print)	n Street, E		•	
Sta Regist			rar's Signature	esti	. Norcett g I	OCT CTHOT C	, rarytail	u 21201

			1- State Registra Amend Item #6	State of Mar Per FH G	yļæ5170 850 12 <i>[</i>	orficisatmof	lealth and M Death	1ental Hygie Reg.		35836
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Death Month	^{Day} 19,2 ^Y 0°0	3. Time of Death
	/Medic	al	HENRY 4a. Facility Name (If not institution, give st.		DAVIS	4h City Town o	Location of Death	October	4c. County of Dea	
	Examin	er	809 Westmore A				ville		Montgo	
	Funeral Director		5. Social Security Number 6. Sex 217-32-2424	7. Age ('In yrs. last birthe Yr	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Dec 16.	9. Bir 1919 Di	thplace (State or Foreign ountry) St Of Col.
	ס		Usual Residence of Decedent 10a, State 10b, County		On City Town			200 10,	<u> </u>	
	Aaryla shov	ō			0c. City, Town o	ockville				10d. Inside City Limits XXYes 2 □ No
	the N	Director	Md Montgome 10e. Street and Number	ry		10f. Zip Code		10g.	Citizen of What C	ountry?
	th with 23e ou	al Di	809 Westmore	Ave,		2085	0		U.S.A.	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or after treumetic event, it a Medical Exameration is called any once.	by Funeral		2. Was Decedent Ev Armed Forces? 1 Yes 2 □ No	er in U.S.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes ŽŽNo	ispanic Origin? (Spi an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
9	2 hou	ted t	15. Decedent's Educa	ation	16a. D	ecedent's Usual Occup	ation	166	o. Kind of Business	
21215-0036	within 7, iene. than "n	Completed	(Specify only highest grade Elementary/Secondary (0-12) 9th Grade	College (1-4or 5+)	((Give kind of work done of the DO NOT use retired Minister	during most of works (Ret)	1	Church	
	at Hyg at Hyg other vent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, Maid	den Sumame)	
Maryland	should be f and Mental I s marked of umetic eve	2	James W. Davi				Agne			
Mar	d 2 sh th and th and 7 is m treum		19a. Informant's Name/Relationship (Type Henry M. Davis	e, Print) (Son)		Address (Street				
	f Heal f Heal item 2		20a. Method of Disposition		20b. Place of D	2617 Bedfo hisposition (Name of crematory or other place			STOWN	
altimore,	Page nent o		XXSurial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	moval from State				25/05 R	ockvill	e. Md
Balt	permit. Departr Imports any inju		2) signature of Funeral Service Coense	man De	1 AIR					e, Md lome, P.A. e, MD20850
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the	e death. Do no	t enter the mode of dyin	g, such as cardiac o	or respiratory arrest,		Approximate Interval Between
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)			FAILURE				Onset and Death 5Yrs
	Examiner	_	Sequentially list conditions, b.	HYPERTE	ENSION					20 Yrs
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Eus to (or as a r	otteecjastice or				.,	
60,	ficate be executed physician and is the burial-transit	ai Exa	resulting in death) Last	Due to (or as a o	consequence of)	:				
68760,		edicai	d.							
P.O. Box	The law requires that the death certi ate has been signed by the attending bage 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome of 1 Live birth 2 4 Pregnant at tir 9 Unknown	Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of de Month	livery Day Year
	w requires that is been signed by should be deta	by	Part II. Other significant conditions control CARD	ributing to death but			en in Part I.			o the cause of death?
COL	law requas been 2 shoul	olete	HEMO	GLOBINO	PATHY			24a. Was an	24b. Were a	utopsy findings available
E Re	The la	Completed						autopsy performed 1 ☐ Yes 2X	? death?	completion of cause of 2 □ No
Vita	sician certifi rector,	Be	25. Was case referred to medical examiner?	spital:		otiont 30 DOA Oth		(Check only one)		
Division of Vital Records,	ing Phys After this uneral di	on: To	1 ☐ Yes 3 ☐ No 27. Manner of Death 11 ☐ Natural 5 ☐ Pending	1 ☐ Inpatient 28a. Date of Injury (Month, Day)	28b. Tin	ne of 28c. Injury	/ at	me 5 Residence 28d. Describe how in		cify)
risio	Attendi death ctor: A	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury	- At home, farm	M 1	Yes 2□No	28f. Location (Street	t and Number or R	ural Route Number,
<u>S</u>	s after s al Dire	Certi	4 Homicide	building, etc.		,,		City or Town, Si		
	To the Hospitel or Attending Physician: The Is within 24 hours after death. To the Funeral Director; After this certificate ha completely filled in by the funeral director, page 2	edical	29a. Cartifier tX Certifying Physic (Chrick only of the Control o	cian: To the best of er: On the basis of each and manner state	xamination and/	death occurred at the tin or investigation, in my o	ne, date and place, pinion, death occurr	and due to the cause ed at the time, date	e(s) and manner as and place, and due	s stated. e to the cause(s)
	vithii To th	Ň	29b. Signature and tyle of certifier		. 7	29c. License			Date signed (Mont	
	4		30. Name and address of person who com	C COQ	th (Item 23a) (To		0443	06	ctoper	20, 2005
)l Seven :	Locks Ro	l, Rockv.	ille, M	đ
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 4 200	32 Registrar's	s Signature	Garles				

hysician	1. Decedent's N	ame (First, Middle	, Last)			tificate c			2. Date of D			Year	3. Time of Death
/Medical				ixon					Octob				4:40P
Examiner	101		, give street and nu			4b. City, Towr		n of Death		40	c. County of		
neral	5. Social Securi		ice Cente		s. last birthday)	I Under 1 Ye		ler 24 Hrs.	8. Date of B	lirth	Howar		ace (State or Forei
tor	579-76-	-1030	1 ☐ M 2 🔀 F		47 Yrs.	Months Day	ys Hour	s Min.	Aug.	Day, Yθar, 5, 19)	Coun	ginia
ompleted by Funeral Director	Usual Residence	e of Decedent		10c C	ity, Town or Loc	ration			1776			11	Od. Inside City Limi
٥			3	100.0		umbia							1 ☐ Yes 2 🔀 N
Director	Md.	Howar Number	<u>a</u>		COTI	10f. Zip Cod	e			10a. Ci	itizen of Wh	nat Coun	trv?
O	8744	Airy Bri	nk Lane				1045				U.S.A.		
Funerai	11. Marital State			cedent Ever in l	U.S. 13. W	Vas Decedent o		Origin? (Spe	ecify Yes or N		14. Race	- Americ	
y Fu		Married 2007 Marri	ied 1 □Yes If Yes, G	2 ★ No		Yes 2			nican, etc.,		Specify:	White, 6	ack
ed by	3 U Widowe	d 4 Divorced	Year or I	Dates:	16a Danadi	anda Harral Oa				105 14			
Completed			t grade completed,		(Give k	ent's Usual Oci and of work do. OO NOT use ret	cupation ne during m tired)	ost of worki	ng	16D. K	Kind of Busi	iness/ind	lustry
E	Elementary/S	econdary (0-12)	College	(1-4or 5+)		oto Cle				Pho	otogra	aphy	
Be C	17. Father's Na	ne (First, Middle, I	Last)				18. Ma	ther's Name	(First, Middi				
To	Ro	bert S	teele			***		Jeanet	tta	Stee	ele		
		s Name/Relationsh				g Address (Stre							
1	Michael 20a. Method of		(Husband)		_	Three			Lexing	-			
	™ Burial	2 Cremation	3 Removal from	Jiaio	Place of Dispos cemetery, crem]			ocation - C	•	
		on 5 Other (Sp	_	Mt	.Zion Ce				2,2005				
	100		1 /		Cha	ambers	Funer	al Hor	ne & C	remat	toriu	n, P	.A.
	/ V / K	1131/	who in	man.	1188 580	01 Clev	re 1 and	AVA	Riverd	ale.	Md . :	2073	7
	23a. Part1. Ent	er (he disease, or	complications that	caused the dea	1/1/8/280	OT CTEA	reland	Ave.	kivera	ате,	Md. 2	2073	Approximate
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			State of Maryland / Depar	tment of Health and M ificate of Death	ental Hygie	2°005	35838
	Dhysisi		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Rena W. Davis		October I	19, 2005	20:25 M
	Examin			4b. City, Town, or Location of Death		4c. County of Deat	
			Prince George's Hospital Center	Cheverly		Prince (
	Funeral Director		577-22-7901 1 M 20 F 82 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y Jan 12,	L923 Sout	hplace (State or Foreign untry) Ch Carolina
	and *	}	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Loca	ation			10d. Inside City Limits
	Aaryli r sho	ō		Bowie			1 ∑ ¥es 2 □ No
	the h	Director	Maryland Prince George's 10e. Street and Number	10f. Zip Code	100	. Citizen of What Co	untry?
	with 3e or		12718 Hillmeade Station Drive	20720		USA	,
	ms 2:	lera		as Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto I	cify Yes or No-	14. Race - Ame	
ထ	or Ita	Für	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔯 No		Rican, etc.)	Black, White	e, etc.
8	ral', c	d by	3 XWidowed 4 □ Divorced If Yes, Give Year or Dates:	☐Yes 2MS No Specify:		Specify: BI	Lack
5	72 h	etec	(Specify only highest grade completed) (Give kii	nt's Usual Occupation nd of work done during most of working	16 19	b. Kind of Business/	Industry
21215-0036	filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or Itams 23e or 28e-f show ant, I'm Medical Examination must be notified at	Completed by Funeral	Elementary/Secondary (0-12) College (1-4or 5+)	NOT use retired) Homemaker		Priva	ato.
	Hygie Hygie ther t	ပိ	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma	*	· · · · · · · · · · · · · · · · · · ·
Maryland	Mental arkad o	To Be	Columbus Williams, Jr.	Minn	ie Anders	son	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any Injury or other traumatic event, the Medical Examinat must be notified at once.			Address (Street and Number or Rura Hillmeade Station		•	
ore,	of Her		20a. Method of Disposition 20b. Place of Disposition 20c. emetery, crema	itory`or other place)		c. Location - City or	Town, State
Ĕ	Page ment ant: If ury o		1X Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify) Harmony Ce	emetery 10/29	/2005	Landover,	, MD
Baltimore,	permit. Departr Imports any Inj			Name and Address of Facility Lat: 06 Kent Town Drive			•
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	the mode of dying, such as cardiac o	r respiratory arrest		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition				Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				,
		-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
	uted ansit	Examiner	Cause (Disease or injury				
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68760,	te be ysicia te but	cai	d				
68	tific as						
Вох	death certificate t e attending physion of for use as the t	an/h	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ E	ctopic pregnancy		23d. Date of del	. ,
O. E	0 0 2	by Physician/Med	in the past 12 months? 1 Yes 2 Ho	Other (specify)		Month	Day Year
P.O.	res that the igned by be detact	Ph	Part II. Other significent conditions contributing to death but not resulting in the und	lerlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
rds,	requires that the leen signed by th hould be detache		Artenioscherotic Candiovasa	Man Disease	1 🗆 Yes	2 No 3 Pr	obably 4 Tunknown
00		Completed	Dighetes Mellitus		24a. Was an	24b. Were au	topsy findings available
Re	9 L B	omp			autopsy performe 1 Yes 2	d? prior to death?	completion of cause of
ta	ician: Th	Be C	25. Was case referred to medical	26. Place of Death		NO TOTOS	2 NO
\geq	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3□ DOA Other: 4□ Nursing Hon	ne 5 🗆 Residenc	e 6 Other (Spec	cify)
0	ding Physician: n. After this certification: funeral director,		27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of (Month, Day Year) 28b. Time of Injury		8d. Describe how		
ioi	Attending r death. ector: After by the fune	atic	2 Accident investigation	M 1 Yes 2 No			
Division of Vital Record	of or Attendated after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	et, factory, office	8f. Location (Stree City or Town, S	et and Number or Ru State)	iral Route Number,
	To the Hospital or Attent within 24 hours after death To tha Funarel Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death of the best of my knowledge,	occurred at the time, date and place, a stigation, in my opinion, death occurre	nd due to the caused at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To tha complet	Me	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Monti	h, Day, Year)
•			Punchen Devore in	DO1852	0	chosen	20 2005
R	(3)		30. Name and address of person who completed cause of death (Item 23a) (Type, Pr	int) Passour Red Hy	attsui1	lle MeD 2	-0781
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 1 2005				
				~			

Hospitel or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760 Division of Vital Records, the

Physician

/Medical

Examiner

Funeral

Director

28e-f show

Funeral Director

Completed by

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i Health and Menial Hygiene. Itam 27 is marked other then "natural", or Itams 23a or 28e-f ehov other traumatic event, the Macilical Exeminer must be nutitied at

filed within 72 hours after

Maryland 21215-0036

Baltimore,

Department of Importent: If it eny injury or o 23a. Part1. Enter the disease, or complications that used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine burial-transit that initiated events resulting in death) Last physicien Physician/Medical the IF FEMALE: 23b. Was decedent pregnant Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by has e 2 page 25. Was case referred to medical P 27. Manner of Death Certification: Director: A d in by the fi within 24 hours a

To the Funeral C

completely filled i 29a. Certifier Medical 29b. Signature and title of pertifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10801 LOCKWOOD DR. SUITE 205, SILVER SPRING, MD. 20904 DOROTHY SEAY, M.D. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State OCT 24

Registrar

	For State	State of Marylar	nd / Depa	artment of H	ealth and M Death		gier () ()	5 35840
Physician	Registrar 1. Decedent's Name (First, Middle,	Last)	OT		204177	2. Date of De.	ath Day	3. Time of Death
/Medicat Examiner	4a. Facility Name (If not institution,	give street and number)	UE 1	4b. City, Town, or	Location of Death	cct	4c. County	905 2210 M of Death
Lammer	HANNE Arus	del Gen F	tosp		A pole	5	A	A
Funeral Director	5. Social Security Number 224-68-2905	5. Sex 7. Age (<i>lñ yr</i> s. 1 X M 2□ F 58	. iast birtnday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bird (Month, Da May 3	y, Year)	9. Birthplace (State or Foreign Country) Pennsylvania
land ow	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
vith the Mary or 28e-f sh ce notified		lington Ar	lingto					1 ☐ Yes XIXNo
3e or 2	10e. Street and Number 2912 N. 7th S	.+		10f. Zip Code 22201			10g. Citizen of V USA	Vhat Country?
urs after death value after the remark 23 mile of the remark 23 mile of the remark 23 mile of the remark 24 mile of the remark 25 mi	11. Marital Status ↑★▼Never Married 2 Marrie	12. Was Decedent Ever in L Armed Forces? 1 TYes 2 □ No		Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto Specity:	ecify Yes or No Rican, etc.)	14. Race Blace Specify	e - American Indian, kk, White, etc.
72 hor 72			16a, Dece	dent's Usual Occupa kind of work done o DO NOT use retired	ation during most of work)	ing		White usiness/Industry
Hygien Hygien ther ther ther the		ast)	Telec	communic	ations 18. Mother's Nam	e (First. Middle.		ommunications
2 should be filed within and should be filed within and Mantal Hygiene. It is marked other than eumatic event, to My					Margare	t R. R	itter	<i>"</i>
d 2 sho th and I T is ma treuma	19a. Informant's Name/Relationshi			ng Address (Street a				State, Zip Code) Grove, VA2250
es 1 and of Health filem 27 fother tr	Linda A. Tomb	20b.	Place of Dispo	sition (Name of matory or other place	e)	Date		City or Town, State
permit. Pages 1 and 2 should be Department of Health and Mentel Importent: It items 27 is marked eny injustrial other treumstic once.	Y Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Fugeral Service ☐	P		Nat'l	10/2	4/2005	Trian Funera	gle, VA
permit. Departr Import. eny inj.	1/1/// st	£		3200 Gol	ansky B	lvd. W	loodbri	dge, VA 22192
Physician /Medical Examiner	23a. Part 1. Enter the disease of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	complications that caused the dealiny of cars, in each line. a. Due to (or as a conse	scler	er the mode of dying	g, such as cardiac IEAV+	or respiratory and	seas	Approximate Interval Between Onset and Death
To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 burs after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification: To Be Completed by Physician/Medical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	7 14004					
that the death certific ed by the attending p detached for use as		23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	aldeath 3[Ectopic pregnancy Other (specify)			23d. Dat Moi	e of delivery nth Day Year
w requires that should be detail should be detailed by Ph	Part II. Other significant condition	ns contributing to death but not re			en in Part I.			ribute to the cause of death?
stcien: The law requires to certificate has been sirector, page 2 should be Completed						24a. Was autop perfo 1 □ Yes	rmed?	Were autopsy findings available brior to completion of cause of death?
hysicien hysicien this certification of the director.		Hospital: 1 ☐ Inpatient 2 ☐	R/Outpatier	nt 3□ DOA Othe	26. Place of Deat		<i>ine)</i> dence 6 □Othe	ar (Specify)
To the Hospitel or Attending Physicien: The lwithin 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page. Medical Certification: To Be Com	27. Manner of Death 1 Matural 2 Accident investigs 3 Suicide 6 Could no	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injury Work	at		now injury occurr	
tel or Att rs after d el Direct ed in by Certifi	3 Suicide 6 Could not determine			reet, factory, office		28f. Location (S City or Tov		er or Rural Route Number,
the Hospi thin 24 hours the Funer impletely fill	29a. Certifier (Check only one) 1 Certifying 2 Medicel E	Physician: To the best of my kn examiner: On the basis of examin and manner stated.			oinion, death occur	red at the time,	date and place, a	
5.	1/1/lillen	P. Com	mi	7		- 1	-	
10+1	30. Name and address of person w	O. JONES	mi	Print) 695	- Ame	rccA	21	035
State Registrar	31. Date filed (Month, Day, Year)	32. Aegistrar's Sign	ature	ede	,			

State of Maryland / Department of Health and Mental Hygiepe 0 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** OCTOBER 20, FOGLE 2005 FRANCIS 11:47A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 10 M 20 F • 93 Yrs Maryland June 11, 1912 Director 214-10-3101 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Itam 27 is marked other then "natural", or Itama 23a or 28a-f show other traumatic event, the Medical Example must be notified at 1 Yes 2 No Frederick Frederick Director Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21701 200 E. 7th Street U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status e filed within 72 hours after all Hygiene.
other then "natural", or itel 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pattern maker Ft. Detrick 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if Item 27 is marked other any injury or other traumatic event spice. 18. Mother's Name (First, Middle, Maiden Sumame) Be Grace Wolf Alphus Fogle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Godel, 200 E. 7th Street, Frederick, Maryland 21701 19a. Informant's Name/Relationship (Type, Print) Urith M. Fogle - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 D Burial 2 Cremation 3 Removal from State 10-24-2005 Frederick, Maryland Olivet Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland sharow Camelle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Yes 2 No should be detached 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes been 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed 2 🗌 No 1 Yes 2 No 1 Tyes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 Yes 2 No death. 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after To the Funerei Dire To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) de 30. Name and address of persent who completed cause of death (Item 23a) (Type, Print) Toll House 801

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene [] 5 35844 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** MARY ANTOINETTE **FURNARY** 17 October 2005 3:15 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MCHS- Potomac Nursing Home Potomac Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☐ M 2🕱 F Yrs. Director 579.10.7035 87 Sept. 9, 1918 Washington, DC Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or items 23e or 28e-f ehow 1K Yes 2 □ No Maryland Montgomery Silver Spring Direct 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 517 Blick Drive 20904 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status e filed within 72 hours after de Il Hygiene.
other than "natural", or item Black, White etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2 Years Real Estate permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygiel important: if item 27 is marked other tt any injury or other traumatic event, IL1 once. Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anthony Guy Furnary Jennie Negro 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 517 Blick Drive, Silver Spring, Maryland 20904 Benjamin G. Furnary/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Fort Lincoln Cemetery 10/22/2005 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. Ola Woundl 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive Heart Failure /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter or Jerry in Cause (Disease or injury that initiated events resulting in death) Last Renal Insufficiency Due to (or as a consequence of): Examiner death certificate be executed physiclan and s the burial-transit Due to (or as a consequence of): Physician/Medical for use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ▼ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Tes 2 No 3 Probably 4X Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 No 1 Yes 2**∑** No 1 Yes or Attending Physician: rector, Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Other: 2 1 ☐ Yes 2 【XNo 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specily) funeral dir this Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 XNatural 5 Pending Injury s after death. M 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D filled the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tit of certifier 40051280 October 19, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9715 Medical Center Dr, Ste. 201, Rockville, MD 20850 Troung Bao, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State COPARIS Registrar

State of Maryland / Department of Health and Mental Hygiene

35845 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Effie Mae Grimes 21,2005 /Medical October 6:05AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ta

8. Date of Birth
(Month, Day, Year)
--- 1 23,1915 Charles County Nursing Rehab Center La Plata Charles 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** Sex 1☐ M 2☐ F Birthplace (State or Foreign Country) Days 220-40-6760 Yrs. Director 90 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural" ~ ... any injury or other treumatic avanta. 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits MD Charles La Plata Funeral Director Y☐ Yes 2☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10200 La Plata Road 20646 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 No 3 XWidowed 4 □ Divorced Specify: white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Farmer Farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Norvel Perry Cooksey Effie Martha Moreland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3152 Apple Creek Lane, Waldorf, MD 20603 Steven Grimes/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Memorial Gar. 10/25/05 Waldorf, Maryland M00945 ²²AREHART-ECHOLS FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee P.O. BOX 567, LA PLATA, MD 20646 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) Alzheimer's Disease /Medical Examiner Due to (or es a consequence of): Examine Hypertension The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuee of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown þ Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificete has b director, page 2 s 1 Tes 2 No 1 ☐ Yes 2 ☐ No or Attending Physiclen: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4M Nursing Home 5 - Residence 6 - Other (Specify) Certification: To 1XYes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred 1 X Natural 5 Pending efter death. Director: Aft investigation 1 Tes 2 No 2 Accident the To the Hospital or Atter within 24 hours efter des To the Funeral Director completely filled in by th 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. Medicai 25 Medical Exeminer: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 14 D0050883 10 21 2005 and address of person who completed cause of death (Item 23e) (Type, Print) Yahia Tagouri,M.D. 11655 Winesapp Place, La Plata, MD 20646 32. Figistrar's Signature State

DHMH 16 Rev 6/95

Registrar

2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15 Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear **Physician** Pauline Gist October 20, 2005 0900 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2010 Carousel Dr. Westminster Carroll 8. Date of Birth (Month, Day, Year) April 11 1930 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days 1 M 2 K F Yrs. Director 169-24-7465 Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itams 23a or 28e-f show the Medical Examinar must be multiled at MD Carroll Westminster 1 Tyes 2 Two Director 10f. Zip Code 10e Street and Number 10g, Citizen of What Country? 2010 Carousel Drive 21157 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Specify à 3 ☐ Widowed 4 St Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Importent: If itam 27 is marked other than "ns any injury or other traumatic avent, The Media 2006. Carroll Hospital Elementary/Secondary (0-12) College (1-4or 5+) 12 Dietary Dept Center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Sadie Bucher Grant Gassert 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Gist/son 441 Warfieldsburg Road Westminster, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 10/2472005 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Meadow Branch Cemetery Westminster, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityPritts Funeral Home & Chapel, PA 412 Washington Rd. Westminster, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Hypertension > 6 years /Medical Due to (or as a consequence of): Examiner perlinidence Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 ☐ Yes 2 ☐ No 1 Yes 21**X** No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No ဥ Diractor: After that in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

Box 68760, of Vital Records, P.O. or Attanding Physicien: Division after

To the Hospitel within 24 hours a MSL 4

30. Name and address of person who ampleted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Dav. Year) State

29a. Certifier

29b. Signature and title of certifier

RULLE

Medical

32. Registrar's Signature

D.O .

Pamela Pagano - Pickre 1 D.O. 1380 Program way Figershung MD 21789 Glown & Spark

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

H50774

29d. Date signed (Month, Day, Year)

Registrar

	1	State of Maryland / C - State of Maryland / C - State of Maryland / C - State of Maryland / C - State of Maryland / C - State of Maryland / C - State of Maryland / C	epartment of Health and Me Certificate of Death	ental Hygie	2e005	35847
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Physiciar /Medica		SALLY M.	61BSON 6	CTUBER	20 2005	1005 PN
Examine	r	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	,	4c. County of Deatl	h
		THE JUHNS HOPKINS HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last birt.	BALTIMORE C, 4 y	8. Date of Birth	SHETIN	10.CE
Funeral Director		- 40 00 (ADI) ITH OFFE PO	Months Days Hours Min.	(Month, Day, Y	1923 NE	pplace (State or Foreigntry) WYORK
Mo Til	⊢	10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limit
Examiner must be notified at the Examiner must be notified at the European Director	į	PA LANCASTER BRUIL	MORE TOWNSH	P		1 ☐ Yes 2 N
r 28	Funeral Director	10e. Street and Number	10f. Zip Code		. Citizen of What Co	untry?
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ams er m	Tue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto R	ify Yes or No- lican, etc.)	14. Race - Amer Black, White	
TO I	Dy L	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 It No Specify: WH	ME	Specify:	1117
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tic ay	0	WILLIAM MALCOLM MAT	HER MARY A	146457	PA SICI	KSON
is markad o aumatic ava		19a. Informant's Name/Relationship (Type, Print) 19b.	Mailing Address (Street and Number or Rural	200	City or Town, State, Z	ip Code)
n 27 iar tra	9	JOHN GIBSON 17		RIVE	DEUM ORE	PA17518
If item 27 is marked other than "nature or other traumatic event, Ite Madical or other traumatic event, Ite Madical To Re Commission		Cemeter	Disposition (Name of Da , crematory or other place)		c. Location - City or	Fown, State
ury o		'4 □Donation 5 □Other (Specify) EVAVS	EAGLE CRENATURY 101	24105 1	LEOLA.	AA
Important: if item 27 any injury or other tr		21. Signal re of Funeral Service Licensee	22. Name and Address of Facily Lee A. Patterson & S 'Perryville, Maryland	on Funer	ral Home, 3-0766	P.A.
		23a. Part1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.				Approximate Interval Between
sician -		Immediate Cause (Final	ANCER		3	Onset and Death
edical		resulting in death) Due to (or as a consequence of				FIVE MONTH!
miner		Sequentially list conditions, b.				
Sit Sit	2	if any, leading to immediate Due to (or as a consequence of cause. Enter Underlying	f):			
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physician and the burial-transit	<u>=</u>		···			
physicials the burning	S C	d				
attending p	J/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deli	verv
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page 2 should	מב			24a. Was an autopsy	24b. Were aut	topsy findings availabl
age yage	ة ق			performe	d? death?	ompletion of cause of
ertifica ector, p		25. Was case referred to medical	26. Place of Death (A
his ce I direc		examiner? 1 ☐ Yes 2 IN No Hospital: 1 Inpatient 2 ☐ ER/Out	patient 3 DOA Other: 4 Nursing Home	e 5 Residenc	ce 6 Other (Spec	ify)
		27. Manner of Death 17 ✓ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) In	ime of 28c. Injury at 28 jury Work?	3d. Describe how	injury occurred	
or: A he fu	g	2 Accident investigation	M 1 Yes 2 No			
To the Funaral Diractor: After t completely filled in by the funera Medical Certification	Ē	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	3f. Location (Stree City or Town, S	et and Number or Rui State)	ral Route Number,
lled C			W			
etely a	Medical	29a. Certifier (Check only one) 1 ★ Certifying Physician: To the best of my knowledge, 2 ★ Medical Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and place, an Vor investigation, in my opinion, death occurred	d due to the caus d at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
omple Me	3	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Month	, Day, Year)
- 0	P-8-10-81-1	> 5	RES-000	01	TOBER 20	, 2005
		30. Name and address of person who completed cause of death (Item 23a) (, , , , , , ,
	7.5	SUSAN CHENG, THE JUHNS HOPKINS H	**	r. BALTIA	NORE MD	21287
State	2	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
Registrar		OCT 2 4 2005 Been 15 49	BASE			
	_					

			1 - For Amend Items 1 - State Registrar	State of Maryland	Certif	1903/05 icate of L	ealth and r Oeath	Mental Hygio	en@ 0 0 5	35848	
			1. Decedent's Name (First, Middle, Last					2. Date of Death		3. Time of Death	
	Physicia		Mildred	Reynolds G	ifford			September	15, 2005	0145 A M	
5	/Medic Examin		4a. Facility Name (If not institution, give		41	c. City, Town, or	Location of Death		4c. County of De	ath	
	LAGITIII	CI.	Calvert Manor Hea	1thcare Center		Rising S	Sun		Cec	1	
	Funeral Director		5. Social Security Number 6. Se		st birthday) If	Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 18), Feb. 18,	^(ear) 1922 Ma	irthplace (State or Foreign Country) aryland	
	D.		Usual Residence of Decedent	10. 0:1.	Town out one					10d. Inside City Limits	
	how		10a. State 10b. County		Town or Locati	on				1 Yes 2 No	
	Ba-f.	Directo	Maryland Cecil	E1	kton						
	ith th	Sire	10e. Street and Number	**		10f. Zip Code		10	g. Citizen of What	200	
	23a		790 West Pulaski	Highway			21921		United		
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, if a Medical Exaction in the routified at ance.	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give ↑ Year or Dates:		Decedent of Hiss, specify Cubar	spanic Origin? (S) n, Mexican, Puerti Specify:	pecify Yes or No- o Rican, etc.)	Black, Wi	nerican Indian, nite, etc. hite	
Ą	2 hor	ted	15. Decedent's Ed		16a. Decedent	's Usual Occupa	ition		6b. Kind of Busines	ss/Industry	
7	n o	Completed	(Specify only highest grad	College (1-4or 5+)	life. DO	NOT use retired)	uring most of wor	A	erospace		
7	yiene giene r tha	mo	Elementary/Secondary (S-12)	2	Secret	ary		I	ndustry		
Maryland 21215-0036	uid be filed Aental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last) Curtis Spencer	Reynolds			18. Mother's Nam Anna Me	ne <i>(First, Middl</i> e, <i>M</i> i cVey	aiden Sumame)		
ary	should and Men marke umatic		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailing A	ddress (Street a	nd Number or Ru	ral Route Number,	City or Town, State	, Zip Code)	
	and 2 Balth a n 27 is		Kirk C. Gifford/S				_	hway, Elk	ton, MD	21921	
Baltimore,	Item		20a. Method of Disposition	20b. Pla	ace of Disposition	on (Name of ory or other place	Soptor		oc. Location - City	or Town, State	
Ę	Pages nent of i int: If it	Ιij	1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	ds Burial		20	mber 19, 05	alvert, l	Marvland	
Ħ	permit. Departm Importa any inju		21. Signature of Funeral Service Licen				s of Facility				
ä	permi Depa Impo any ii		I musel &	Colubb	103	W. Sto	ckton St	erals, P. ., Elkton	. MD 2192	21	
Print No. 198	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or companies shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list condition if any, leading to immediate cause. Enter Underlying	a. Due to (or as a consequence of the death.) Due to (or as a consequence of the death.)	once of):	_	2.5-2	ciology ur		Approximate Interval Between Onset and Death	
8760,	ate be executed thysician and the burial-transit	Jical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequent)	ence of):		CERTIFICATIO	N APPROVED BY MEI	OICAL EXAMINER		
P.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3□Ec	topic pregnancy ther (specify)			23d. Date of o	delivery Day Year	
	w requires that been signed b should be deta	y Pl	Part II. Other significant conditions of				en in Part I.	23e. Did toba	cco use contribute	to the cause of death?	
rds	quire an sig uld b	edk	Parkinson's	Disease, Al	herosc	Lerotic		1 🗆 Yes	2 2Mo 3□	Probably 4 Unknown	
Vital Records,	The law re cate has bee page 2 sho	Completed by	cardiovasc	ılar disease				24a. Was an autopsy perform	prior t		
								ith (Check only one)		
ita		0	25. Was case referred to medical					e 5 ☐ Residence 6 ☐ Other (Specify)			
f Vita	ysician: is certifica director, I	Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatient	3□ DOA Othe	or: Nursing H	ome 5 ∐ Hesider	ne how injury occurred		
of Vita	Physician: rthis certifica ral director, I	To Be	examiner? 1 Xes 2 2	28a. Date of Injury	ER/Outpatient 28b. Time of Injury	3 DOA Other	at Nursing H			oecity)	
Division of Vita	or Attending Physician: fter death. Director: After this certifica in by the funeral director, I	To Be	examiner? 1 XYes 2 YO	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at Nursing H	28d. Describe how	v injury occurred	Rural Route Number,	
Division of Vita	or Attending Physician: fter death. Director: After this certifica in by the funeral director, I	Certification: To Be	examiner? 1	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At hor	28b. Time of Injury me, farm, street	28c. Injury Work 1	rat (?) Yes 2 No	28f. Location (Streetly or Town,	vinjury occurred set and Number or State) use(s) and manner	Rural Route Number, as stated.	
Division of Vita	or Attending Physician: fter death. Director: After this certifica in by the funeral director, I	To Be	examiner? 1	28a. Date of Injury (Month, Day Year) 28a. Place of Injury - At hose building, etc. (Specify) ysician: To the best of my knowniner: On the basis of examinat	28b. Time of Injury me, farm, street	28c. Injury Work 1	re, date and place	28d. Describe how 28f. Location (Stractive or Town, City or Town, and due to the cau	vinjury occurred set and Number or State) use(s) and manner	Rural Route Number, as stated. ue to the cause(s)	
Division of Vita	Attending Physician: or death. ector: After this certifics by the funeral director, I	edical Certification: To Be	examiner? 1	28a. Date of Injury (Month, Day Year) 28a. Place of Injury - At hose building, etc. (Specify) ysician: To the best of my knowniner: On the basis of examinat	28b. Time of Injury me, farm, street	28c. Injury Work M 1 \(\text{1} \) , factory, office	re, date and place	28d. Describe how 28f. Location (Stractive or Town, City or Town, and due to the cau	winjury occurred set and Number or State) use(s) and manner se and place, and d	Rural Route Number, as stated. ue to the cause(s)	
Division of Vita	or Attending Physician: fter death. Director: After this certifica in by the funeral director, I	edical Certification: To Be	examiner? 1	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At hor building, etc. (Specify ysician: To the best of my knowniner: On the basis of examinat and manner stated.	28b. Time of Injury me, farm, street vledge, death or on and/or inves	28c. License	real and place pinion, death occurs number	28d. Describe how 28f. Location (Stra City or Town, 1, and due to the cal 1rred at the time, da	winjury occurred set and Number or State) use(s) and manner se and place, and d	Rural Route Number, as stated. ue to the cause(s)	
Division of Vita	or Attending Physician: fter death. Director: After this certifica in by the funeral director, I	edical Certification: To Be	examiner? 1	28a. Date of Injury (Month, Day Year) 28a. Place of Injury - At hot building, etc. (Specify ysician: To the basis of examinat and manner stated.	28b. Time of Injury me, farm, street vledge, death or on and/or inves	28c. License	real and place pinion, death occurs number	28d. Describe how 28f. Location (Stractive or Town, City or Town, and due to the cau	winjury occurred set and Number or State) use(s) and manner se and place, and d	Rural Route Number, as stated. ue to the cause(s)	

			1 - State of I	Maryland		rtment <i>tificate</i>			ınd M		giere Reg. No.	05	35849
	Physici /Medic	-	1. Decedent's Name (First, Middle, Last) Delores M	•	Ga	.11				2. Date of Dea Month Oct.1)5	3. Time of Death 2:20a M
	Examin		4a. Facility Name (If not institution, give street and number National Lutheran Hom			4b. City, To		Location o	f Death			inty of Death	nery
7	Funeral Director		5. Social Security Number 175-01-3534 6. Sex 1 □ M 2又 F 7.	Age (In yrs. las	st birthday) Yrs.	If Under 1 Months	Year Days	If Under a	24 Hrs. Min.	8. Date of Birt Month, Day Feb. 2	1 , 1 9 1		place (State or Foreign ntry) nna .
	Maryland -f show	tor	10a. State MD 10b. County Montgomery	10c. City,	Town or Lo	cation KVill	e						10d. tnside City Limits 1 ☐ Yes 2 No
	h with the	Funeral Director	10e. Street and Number 1122 Parrish Drive			10f. Zip 0	0 8 5	1			10g. Citizen	of What Cou	ntry?
920	i within 72 hours after death with the Maryland liene. I then "natural", or Hems 23a or 28a-f show It e Modical Examinar rust be multiled at	b	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced 12. Was Decede Armed Force 1 Yes 2! If Yes, Give Year or Date	s? X No	1	Vas Decede f Yes, specif		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto l	ecify Yes or No- Rican, etc.)		Race - Americ Black, White, ecify:	
Maryland 21215-0036	within ane. than "	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-44)	or 5+)	(Give life. l	lent's Usual kind of work DO NOT use Iranc	done a retired,	luring most)				f Business/In	_{dustry} rnment
land 2	Hyg Hyg otha	To Be Co	17. Father's Name (First, Middle, Last) Andrew Gall					18. Mothe	r's Name	(First, Middle, Gomery		name)	
, Mary	S D E E		19a. Informant's Name/Relationship (Type, Print) Sandra Trice/Cousin							Sant, F			ia 15666
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If itam 27 Is any injury professive tra-		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	te cen	netery, cren	sition (Name natory or oth n Cer	er place	10	/21/	/ 0 5		on - City or To town ,	Penna.
Balt	permit. Depart Import any inj		21. Signatura of Ferneral Service Kidensee		6	5 N.G	all	itar	a Av	l Home		n,PA.	15401
	Physician		23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each disease or condition resulting in death)	sed the death.		er the mode			cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
8760,	/Medical Examiner bhysician and sthe burial-transit	cal Examiner	Esquentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	as a conseque as a conseque as a conseque	nce of):	RTER		720	EAS.				
.O. Box 68	death certif e attending od for use as	Physician/Medical		n 2 ∏ Fetal d t at time of dea	eath 3	Ectopic pred						Date of delive	ery Day Year
rds, P.	es be	þ	Part II. Other significant conditions contributing to deat	h but not result	ing in the ur	nderlying cau	nse dive	n in Part I.		23e. Did to			he cause of death? pably 4 □Unknown
of Vital Record	The law ate has b page 2 sl	Completed						-	-	24a. Was autop perfor	sy	b. Were auto prior to co death? 1 \(\sum \text{Yes} \)	psy findings available mpletion of cause of
f Vita	ysician s certifi director	To Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\frac{7}{2} \text{No} \) Hospital: 1 \(\text{Inp.} \)	atient 2□El	₹/Outpatien	t 3 DOA	Othe	r.		(Check only one 5 Resid		Other (Specif	iy)
Division o	ding h. After fune	ertification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of I	njury 2 Day Year)	8b. Time of Injury	286 M	c. Injury Work 1 🔲 Y	at ? ′es 2 □ N		28d. Describe h	ow injury oc	curred	
DIV	ital or Attandurs after deathurs after deathurs ral Diractor; lled in by the	O	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of building.	Injury - At hom etc. (Specify)	e, farm, str	eet, factory,	office		2	28f. Location (S City or Tow		imber or Rura	al Route Number,
	To tha Hospital or Attan within 24 hours after deat To tha Funaral Diractor; completely filled in by the	Medical	29a. Certifier (Check only one) One Simple and title of certifier Continue one title of certifier	s of examinatio		estigation, in	n my op			ed at the time, o	date and plac		the cause(s)
)	5		29b. Signature and title of certifier New Author	-				5115		C	CTOBE	n 10	1 2005
			30. Name and address of person who completed cause of VATTI. T. ANTHONY	9701	WEIM.	De	VE	~	Roc	KUILL	E	MD 20	850
	Sta Registr	_	31. Date filed (Month, Day, Year) 32. Reg 0CT 2 1 2005	istrar's Signatu	e de	ule							

			Terms State of Maryland / Department of Health and Me Registrar Certificate of Death	ental Hygier	_ 0 0 0 0	35850
				2. Date of Death		3. Time of Death
ı	Physici /Medic		Norma Graham O		Day Year 17, 2005	12:45P M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	•	4c. County of Death	
			Anne Arundel Medical Center Annapolis 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I if Under 24 Hrs. 8		Anne Arund	
	Funeral Director		1 M 2 SFF Wonths Days Hours Min.	J. Date of Birth (Month, Day, Yea		ace (State or Foreign try)
	ס		Usual Residence of Decedent	ugust /,	1934 Penn	
	arylar show	_	10a. State 10b. County 10c. City, Town or Location		10	0d. Inside City Limits 1X Yes 2 □ No
	he M.	Director	Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code	100	200	
	with the or S	Dir	10e. Street and Number 877 Clubhouse Village View 21401	log. (Citizen of What Count U.S.A.	try?
	death ms 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Speci	fy Yes or No-	14. Race - America	
စ္	or Ite	Fur	Armed Forces? If Yes, specify Cuban, Mexican, Puerto Ri 1 □ Never Married 2 □ Married I □ Yes 2 ☒ No If Yes, Give I □ Yes 2 ☒ No Specify:	can, etc.)	Black, White, e	etc.
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show fre Modical Examiner mast be motified at	d by	3 ★ Widowed 4 Divorced Year or Dates:		Specify: whit	
5	n 72 l	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)	7 16b.	Kind of Business/Ind	ustry
712	y withi	ошь	Elementary/Secondary (0-12) College (1-4or 5+) 2 Project Specialist		gital Equi	p. Corp.
ğ	e filec al Hyg othe vent,	BeC	17. Father's Name (First, Middle, Last) 18. Mother's Name (i			F F
<u>ya</u>	Menta	To	Craig N. Dorphley Grace Fig.	schle		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any rightry or other traumatic event, Ite Modical Examiner must be netified at ODGs.	9 1	19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural I		LICACIONE INCOME	Code)
e)	1 and Health em 2		Annmarie Dinsmore/daughter 8004 Orchard Fark Way 1 20a. Method of Disposition (Name of Date of Disposition (Name of Date of Disposition (Name of Date of Disposition (Name of Date of Date of Disposition (Name of Dat	Bowie, MI	20715 Location - City or Tox	wn. State
ÕL	Pages ant of at: If it		TGGurial 2 □ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify) To the content of the content		entwood, M	
altimore,	mit. F partme portar / injur		21. Signature of Funeral Service Libensee / 22. Name and Address of Facility For			
Ö	Per Per Per Per Per Per Per Per Per Per		Xan f. Mile 3401 Bladensburg Rd.	Brentwoo	od, MD 207	22
Е			23a. Part1. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition and the condition and		2	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):			
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):		4	
	uted d ansit	min	cause. Enter Underlying Cause (Useas or Injury that initiated events c.			
o,	e exec ian an ırial-tr	Exa	resulting in death) Last Due to (or as a consequence of):			
8760,	icate be executed physician and s the burial-transit	dicai Examiner	d			
9	certific ding p	a)	IF FEMALE: 23c. If yes, outcome of pregnancy		and Data of dalling	
Box	leath certifi attending j I for use as	by Physician/M	in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of deliver Month	y Day Year
o.	res that the de igned by the a be detached f	hysi	9 Unknown			
S, D	es tha gned	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the	e cause of death?
ord	w requir been si should I			1 🗆 Yes	2 No 3 Proba	ably 4 □Unknown
Records,	alawi hasbu e 2 sh	Completed		24a. Was an autopsy	prior to com	esy findings available appletion of cause of
alF	n: The licate r, pag			performed? 1 ☐ Yes		2□ No
=	Physician: The law requires that the death certif this certificate has been signed by the attending rai director, page 2 should be delached for use a	o Be	25. Was case referred to medical examiner? 1 Yes 2 Nuc		6 □Other (Specify	
1 0	g Phy er this eral d	n; To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28	d. Describe how in)
joi	Attending I or death. ector: After by the funer	atio	2 Accident investigation M 1 Yes 2 No			
Division of Vital	or Attendater death Director: / Jin by the f	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28	f. Location (Street City or Town, Sta	and Number or Rural ate)	Route Number,
	ospital of hours at uneral D		29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an	el elus és élus sous	(a) and managed as at	
	H 224	Medical	29a. Certifier (Check only one) Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, date a	(s) and manner as sta and place, and due to	the cause(s)
	To the with n	Me	29b. Signature and title of certifier 29c. License number	29d. [Date signed (Month, E	Day, Year)
Ü.		LL.	> yearnestore my	1	01/8/105	
D	101		30. Name and address of person who completed a se of death (Item 23a) (Type, Print)	MADR .	110711	01
	Sta	10	31. Date filed (Month, Day, Year) 32. Registrar's Signature	101210517	WY 114	V)
	Registr		OCT 2 1 2005 Blow & species			

			For State Registrar	State of M	aryland / Dep	partment of Hertificate of I	lealth and N Death		ene 0 0 5	35851
			Decedent's Name (First, Middle)	, Last)				2. Date of Death	1	3. Time of Death
	Physici /Medic		ALVIN F	GARDNER				10/02/		2305 ^M
	Examin		4a. Facility Name (If not institution,				r Location of Death	1	4c. County of Dea	
			WASHINGTON ADVE		TAL ge (In yrs. last birthda	TAKOMA PA		8. Date of Birth	MONTGO	MERY thplace (State or Foreign
	Funeral Director		263-24-7604	1 ∑ M 2□F	85 Yrs.	Months Days	Hours Min.	(Month, Day, 03-22-1	Year) Co	CHIGAGO, IL
	D D		Usual Residence of Decedent							
	show ad at	5	10a. State 10b. County		10c. City, Town or					10d. Inside City Limits 1X Yes 2 □ No
	28e-f	Director	FL PALM I	BEACH	BOYNTON	BEACH 10f. Zip Code		10	og. Citizen of What Co	
	3a or	<u>a</u>	12570 RAVENNA			33436			U.S.A.	,
	death	nera	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 13	J. Was Decedent of H	ispanic Origin? (St	pecify Yes or No-	14. Race - Ame	
98	or Ita	by Funeral	1 ☐ Never Married 2X Marrie	ed 1 Yes 2	No WW2	1 ☐ Yes 2 📉 No	Specify:	o nican, etc.)	Black, White Specify: WH	
Ö	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28e-f show its Medical Eracinal centilled at		3 Widowed 4 Divorced 15. Decedent	Year or Dates:		edent's Usual Occup			6b. Kind of Business	
5	in 72 n "na	plet	(Specify only highest	t grade completed)	(Gir	re kind of work done of DO NOT use retired	during most of wor	king	db. Kind of business	moustry
21215-0036	giene giene er tha	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	5+)	DENTIST			DENTISTR	Υ
g	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. itam 27 Ia marked other than "natural", or Itams 23a or 28e-f show other traumatic avant. I're Medical Eracini er coust be routlied at	Be	17. Father's Name (First, Middle, L	Last)				ne (First, Middle, M	faiden Sumame)	
Z Za	should be nd Mental nmarked o	^c	LEON GARDNER 19a. Informant's Name/Relationsh	sin (Time Brint)	10h Ma	Nine Address (Street		H KANTER	City or Town, State,	Zin Codol
Maryland	id 2 sl lth an 27 la r traur		AVA MENDELSON-			•			RG, MD. 20	
	s 1 and f Health itam 27 othar ti		20a. Method of Disposition		20b. Place of Dis	position (Name of rematory or other place			Oc. Location - City or	
Ë	Page nent o nnt: If irry or		1 🔀 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		MT. NEB			-06-05	MIAMI, FL	
Baltimore,	permit. Pages 1 and Department of Healt Importent: If itam 2 any injury or othar 900.		21. Signature of Funeral Service L			22. Name and Addres				TNG
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	that the death cered by the attendir detached for use	sicla	in the past 12 months? 1 Yes 2 No			Other (specify)			Month	Day Year
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Vital Record	The law ite has b bage 2 sl	ошр						autopsy perform	ed? prior to death?	completion of cause of
ta		BeC	BLADDER CANCER 25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one	A	20.10
of V	Physician: r this certific ral director,	၉	1 ☐ Yes 2 😾 No	Hospital: 1 🔀 Inpati					nce 6 ☐Other (Spe	cify)
o uc	tending P leath. tor; After t the funera	Certification;	27. Manner of Death 1 ∑Natural 5 ☐ Pending		ury 28b. Time ay Year) Injury	Worl	yat k? Yes 2 □ No	28d. Describe how	w injury occurred	
Division	tend leatl tor; the	ficat	2 Accident Investig 3 Suicide 6 Could n	ot be 28e. Place of In	jury - At home, farm,		162 5 100	28f. Location (Str.	eet and Number or R	ural Route Number,
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	To the Hospitel or At within 24 hours after or To the Funaral Dirac completely filled in by			g Physicien; To the best Exeminer: On the basis						
	the H hin 24 the F nplete	Medical	one)	and manner s						
	70 000	-	29b. Signature and title of certifier	5.5	3	29c. Licenso		29	d. Date signed (Moni	
	nal:		30. Name and address of person	who completed cause of	death (Item 23a) (Tun	D 603	59		10-04-0)5
٠	30+1		SEAN S. SAEDI	· V			SILVER	SPRING, N	1D. 20904	
	Sta Registi		31. Date filed (Month, Day, Year)	32. egist	I- Ci	ball				
		_		-	-					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month John Calvin Hansbrough 19, October 2005 14:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 114 North Main Street North East Cecil 8. Date of Birth (Month, Day, Year) Feb. 1, 1921 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X**M 2□F Days Hours Months Yrs. Director 578-18-4507 84 Washington, DC Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 Is markad othar than "natural", or Itams 23a or 28a-f show othar traumatic event, the Medical Evantral must be rollified ≛I Director TX Yes 2 □ No Maryland Cecil North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 114 North Main Street 21901 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ™Yes 2 □ No If Yes, Give Year or Dates: 1944–45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene.
Is marked other than "natural", or Ital 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ģ Specify. 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Torpedo Factory Elementary/Secondary (0-12) College (1-4or 5+) Machinist Alexandria, Virginia Twelve Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Hansbrough Laura E. Reed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 of Health item 27 Shirley A. Kendall (niece) 5827 Newland Road, Warsaw, Virginia 22572 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If itel
any injury or ott 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 10/21/05 ' 4 ☐ Donation 5 ☐ Other (Specify) R.A. Ferris & Co., Inc. West Chester, Pennsylvania 21. Sign Jure of Funeral Service Licensee 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Sir. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Emphy 52 m a Due to (or as a consequence of): 12ars /Medical **Examiner** Sequentially list conditions, Due to (or as a consequence of) Examiner any, leading to immedicause. Enter Underlying Cause (Disease or injury as the burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year Month 4 Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1

✓ Yes 2

No 3

Probably 4

Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 2 No 1 Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funaral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 0 29d. Date signed (Month, Day, Year) IVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chesapeake Hospice Leson 31. Date filed (Month, 0 2 Yea 2 4 2005 32. Re Registrar

State of Maryland / Department of Health and Mental Hygiene 0.5 35853 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1900 P M OCTOBER 18, 2005 CECIL CARL HOLSTROM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death SNOW HILL NURSING & REHAB CENTER SNOW HILL WORCESTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours 1 XM 2 ☐ F Yrs. Director 89 213**-**38-4979 FEB.7,1916 CONNECTICUT Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic evant, the Madical Examiner must be notified at 1 Yes 2 No Director DELAWARE SUSSEX REHOBOTH BEACH 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 209 THE HENLOPEN CONDOS Funeral 19971 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 MYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1941-1 ☐ Yes 21 No þ Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced "natural", 1946 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. DEPARTMENT OF Elementary/Secondary (0-12) College (1-4or 5+) PHYSICIST $5\pm$ THE NAVY othar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H tant: If itam 27 is marked ott Be ဂ္ CARL LILJENSTEIN <u>ANNA ANDERSON</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or other trae MARY K. HOLSTROM/WIFE 209 THE HENLOPEN CONDOS, REHOBOTH BEACH, DE 19971 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ^¹ 4 □ Donation EASTERN SHORE CREMATORIUM 10/20/05 LEWES, DELAWARE 21. Signature of Funeral Service Licenses 22. Name and Address of Facility ₩00866 PARSELL FUNERAL HOMES & CREMATORIUM 16961 KINGS HIGHWAY, LEWES, DE 19958 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaf failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DISEASE ARTELY LORONARY /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter or derlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the δ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 2 2 No 1 Typs Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending death. 1 Tes 2 No investigation 2 Accident Director 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide a Funaral [29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) tha within To tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) amy 00062172 10/18/2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POLOMOKE CITY SMARAD R SATYAL, MD. 1604 MARKET MD 31. Date filed (Month, Day, Year) 0 CT 2 1 2005 32. Rajistrar's Signature State Registrar

			- State Amend Item	State of Ma 2 per ME	ryland / De , C849 , 11	partment of F 271105dhb ertificate of i	lealth and Me Death	ental Hygiene Reg. No	005 35854
	Physicia		Decedent's Name (First, Middle, Last, THOMAS		KINS		-	2. Date of Death 10	0/18/2005 3. Time of Death
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give	نعال وكوي	(In yrs. last birthd 84 Yrs	ay) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country) 9. MD.
	ryland thow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or			W	10d. Inside City Limits
	h the Ma or 28a-1 e e retiffe	Funeral Director	D . C . 10e. Street and Number		WA	SHINGTON 10f. Zip Code		10g. Cit	1 Yes 2 □ No
	death wi	neral D	4020 Q STREE	T, S.E.		3. Was Decedent of H	lispanic Origin? (Spec	ify Yes or No-	USA 14. Race - American Indian,
9600	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 ie marked other than "natural", or Items 23a or 28a-f ehow other traumatic event, the Medical Examinal must be notified at	by	1 ☐ Never Married 2 【X Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Y Yes 2 No If Yes, Give Year or Dates:	UNK	1 ☐ Yes X☐ No	Specify:		Black, White, etc. Specify: BLACK
21215-0036	within 72 h ene. than "natu	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(G	ocedent's Usual Occup ive kind of work done e. DO NOT use retired PLUMBER	during most of workin	9	FED. GOVT.
land 2	ld be filed ental Hygid ked other ic event, I	To Be Co	17. Father's Name (First, Middle, Last) EUGENE HAW	KINS				(First, Middle, Maider	n Sumame)
Maryland	nd 2 shou alth and M 27 te mar r traumat		19a. Informant's Name/Relationship (7) EDNA HAWKINS/W						or Town, State, Zip Code) D.C. 20020
3altimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F 1 □ Donation 5 □ Other (Specify)	temoval from State	cemetery, o	sposition (Name of crematory or other place IVET CEM ,	Da 10/24		ocation - City or Town, State
Balti	permit. Departn Imports any inlu		21. Signature of Funeral Service Licens		7		•	rson f. F N.W. 200	
	rnysician /Medical Examiner		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	Arteri		enter the mode of dyin	1		Approximate Interval Between Onset and Death
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P.O. Box 68	ath certifi ittending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 24 Pregnant at the 9 Unknown	2 ☐Fetal death	3 Ectopic pregnancy 5 Other (specify)	1		23d. Date of delivery Month Day Year
	quires that the de n signed by the a uid be detached f	by	Part II. Other significant conditions co	ntributing to death bu	t not resulting in th	e underlying cause giv	en in Part I.		use contribute to the cause of death?
Division of Vital Records,	ding Physician: The law requiri h, After this certificate has been sl funeral director, page 2 should b	Completed						24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
f Vit	hysiciar this certif al directo	To Be	25. Was case referred to medical examinar? 1☐ Yes 2☐ No	Hospital: 1 Inpatier	nt 2 R/Outpa	itient 3 DOA Oth	er: 4 Nursing Hom	(Check only one) Be 5 Residence	6 □Other (Specify)
ion o	ttending Ph death. stor: After th the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injun (Month, Day	Year) 28b. Tim Inju	ry Wor	yat 2i k? Yes 2 □No	8d. Describe how inju	ry occurred
Divis		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At home, farm. . (Specify)	street, factory, office	2	8f. Location (Street ar City or Town, State	nd Number or Rural Route Number, e)
	To the Hospital or within 24 hours afte To the Funeral Directions of the Completely filled in h	Medical			examination and/o) and manner as stated. d place, and due to the cause(s)
	To the within 2 To the complete	M	29b. Signature and title of certifier	48-37	2 00	29c. Licens			te signed (Month, Day, Year)
R	(15)		30. Name and address of person who co	1	eath (Item 23a) (Ty	pe, Print)	0553	d	, , , ,
	Sta Regista		31. Date filed (Month, Dal, Year) OCT 2 4 2005		r's Signature		7. 1.4		
DE	MH 17 Rev 1/2	- 4	OO I W # FA03	proces	- 7				

			1 - For State Registrar		Maryland / De	oartmer e <i>rtific</i> at	nt of H	lealth a	and M		Reg. No.	05	3585	
	Physici	an	Decedent's Name (First, Middle	e, Last)						2. Date of Dea	ath Day	Year	3. Time of 0	Death
	/Media		Anne Merle H							October		2005	4:02	p^
}	Examir	er	4a. Facility Name (If not institution		er)			r Location				unty of Death		
		,	156 Wampee Ct.		a de la constant		stmir r 1 Year	nster If Under		I o D		Carroll		-
	Funeral		5. Social Security Number	6. Sex 7. 1 ☐ M 2 ☑ F	Age (In yrs. last birthda Yrs.	Months		Hours	Min.	8. Date of Birt (Month, Da	y, Year)	Cou	place (State or ntry)	Foreign
Ь.	Director		266-34-1367 Usual Residence of Decedent		76 Yrs.					Apr 22	, 1929	Flor	rida	
	/land		10a. State 10b. County		10c. City, Town or	Location				***************************************			10d. Inside City	y Limits
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	r 28s	Director	10e. Street and Number	/ <u>.t. t.</u>	Web Cr.		Code				10g. Citizer	of What Cou	ntry?	
	h wit	a D	156 Wampee Ct.				2115	7			USA			
	deat sms	Funeral	11. Marital Status	12. Was Decede Armed Force	ent Ever in U.S. 13	B. Was Dece	dent of H	lispanic Ori	igin? (Sp	ecify Yes or No Rican, etc.)	- 14.	Race - Ameri Black, White,		
9	after or it		1 Never Married 2 Marr			1 🗆 Yes		Specify:		7 110411, 010.7		ecify:	olc.	
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5	n 72	lete		t's Education st grade completed)	(Gi	cedent's Usu ve kind of wo . DO NOT u	ork done	during mos	st of work	ing	16b. Kind	of Business/In	idustry	
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	Hygi Hygi ther nt, I	ပိ	17. Father's Name (First, Middle,				1	18. Mothe	er's Nam	e (First, Middle,				
Maryland	should be that Mental is marked o	To B	Granville Wil	liam Knowl	es			M	avbe	lle Ail	ene Fo	ox		
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ē,	ss 1 an of Heal item 2		20a. Method of Disposition		20b. Place of Dis	position (Na	me of			Date		ion - City or T		
e E			Page 2 ☐ Cremation Page 3 ☐ Cremation Page 4 ☐ Donation 5 ☐ Other (S)		MD Veter	-			10/2	6/2005	Garri	ison. M	Marylano	d
Baltimore,	그 문문을 .		21. Signature of Funeral Service						-	e and Ch				
ä	Depa Impo any i		John K	MUZ						and Cr Westr			21157	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau	sed the death. Do not a	nter the mod	de of dyin	ig, such as	cardiac	or respiratory ar	rest,	: L p VIL)	Approximate Interval Betw	
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	/Medical		disease or condition resulting in death)		as a consequence of):	700	ردی	-					1 year	V
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8760,	icate be executed physician and s the buriat-transit	Physician/Medical		d										
9	The law requires that the death certificate tte has been signed by the attending physoage 2 should be detached for use as the	Med	IF FEMALE:									-	-	
Вох	eath certific attending p	an/	23b. Was decedent pregnant in the past 12 months?		n 2 ☐ Fetal death	B □Ectopic p		,			23d	Date of delive Month	- /	ea.r
	t the dea by the al	sici	1 ☐ Yes 2 No 9 ☐ Unknown	4☐ Pregnan 9☐ Unknow		Other (s	pecify)					William	Day 16	2011
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Vital	Physician: this certific ral director,	Be	25. Was case referred to medica examiner?	Hospital:			Oth	OF:		Check only o				-
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	urs In In		29a. Certifier Certifyir	ng Physician: To the be	est of my knowledge, de	ath occurred	at the tin	ne, date an	nd place.	and due to the	cause(s) and	d manner as s	tated.	
	24 h	edical		Examiner: On the basi and manner	s of examination and/or	investigation	in my o	pinion, dea	th occur	ed at the time,	date and pla	ce, and due to	the cause(s)	
	To the Hosp within 24 hor To the Fune completely fi	Me	29b. Signature and title of certifie	_ A	ENDING	29	c. Licens	e number			29d. Date si	gned (Month,	Day, Year)	
	1		Dante >1		PHYSICIAN	-	Da	2115	22		OCT.	19 21	005	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10:47 PM 19,_ Norris L. Harrison, October 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 8-21-1946 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 X M 2 □ F Director Yrs 59 Maryland 213-44-0314 Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🎇 No Maryland Anne Arundel Annapolis Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 625 Admiral Drive 21401 USA Itema 23a Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö If Yes, Give Year or Dates: 1969–75 1 ☐ Yes 2 No Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Certified Public Accountant Accounting 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othn sny injury or other traumatic event QDES. 18. Mother's Name (First, Middle, Maiden Surname) Be Sarah Favinger Norris L. Harrison, Sr. ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 625 Admiral Dr., Annapolis, MD 21401 Patricia M. Harrison/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-25-05 Edgewater, MD Kalas Crematory 4 Donation 21. Signatural Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home Ullas 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Physician /Medical Examiner Se psis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine Value Replacement To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit resulting in death) Last Box 68760 Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use copyribute to the cause of death? 2 PNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificete 1⊡ Yes 2 1No 1 ☑ Yes 2 ☐ No r: After this certifice 25. Was case referred to medical examiner? Be 26. Place of Death Check only one examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Unpatient 2 ER/Outpatient 3□ DOA Certification: To 27. Manner eath 1 Platural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No To the Funeral Director: , completely filled in by the f 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide

State Registrar

DHMH 17 Rev 1/2001

Medical

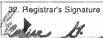
Howard Young MD

31. Date filed (Month, Day, Year)

32. F **DCT 2 1 2005**

29b. Signature and title of certifier.

29a. Certifier



and a dress of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Medical Conter

29d. Date signed (Month, Dey, Year)

Anne Arundel

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician October 20, 2005 3:55pm M Raymond James Henchy /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Montgomery Rockville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Director 155-22-8869 78 12/26/1926 New Jersey Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location l7 is marked other than "natural", or itams 23a or 28a-f show traumatic event, the Madical Examinar must be multified at 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? itams 23a 20201 Shipley Terrace #302 20874 Completed by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 ₩ Widowed 4 Divorced 'natural' White Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+)
2 Year Elementary/Secondary (0-12) Years Accountant Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked of 2 John Martin Henchy Agnes Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if of Health (Daughter) 20201 Shipley Terrace, Germantown, MD 20874 Lu Ann Henchy or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Department of important: if any injury or once. Metropolitan Crematory 10/21/05 Alexandria, Virginia

22. Name and Address of Facility DeVol Funeral Home
10 East Deer Park Drive
Gaithersburg, MD 20877 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 28a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical (or as a consequence of) Examiner Dremorria Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) use as the burial-transit or Attending Physician: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2K No within 24 hours after death.

To the Funeral Director: After this certified completely filled in by the funeral director, I 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) D006243 7+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Agistrar's Signature 31. Date filed (Month, Day, Year) State Registrar 24

			1 - For State Registrar		f Maryla	nd / Depa <i>Cei</i>	artment of F	lealth a Death	and Mental F	Reg. No			
	Physici		1. Decedent's Name (First, Middle, Las Jane M. Hudgins	(t)					2. Date of Month Octobe	Da	y Year 2005	3. Time of Death 6:50 P M	A
	/Medio Examir		4a. Facility Name (If not institution, give	street and nu	mber)		4b. City, Town, o	r Location o			County of Death		_
			Manor Care Potoma				Potomac	T-0			ntgomer	У	
	Funeral Director		5. Social Security Number 6. S 216-64-6914 1 Usual Residence of Decedent	ex □M 2M∏F		. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under Hours	8. Date of (Month, 09/01)	Birth Day, Year) 1924	9. Birth Cou New	place (State or Foreign intry) York	7
	yland 10w		10a. State 10b. County		10c. C	ity, Town or Lo	cation					10d. Inside City Limits	;
	e Mar	ctor	MD Montgome	ry	Po	tomac						1 ☐ Yes 2X No	,
	with th	Director	10e. Street and Number				10f. Zip Code				izen of What Cou	intry?	
	ns 23	erai	10419 Boswell Lar		edent Ever in l	J.S. 13. V	20854	ispanic Orig	gin? (Specify Yes or		U.S.A.	ican Indian	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "naturei", or items 23a or 28a-f show important: If item 27 ie marked other then "naturei", or items 23a or 28a-f show any injury or other traumetic event, it is Maclical Exactificational by notified at ORGE.	i by Funerai	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Fo 1 Yes If Yes, Giv Year or D	rces? 2 X ∃No ∕e	1	f Yes, specify Cuba 1 ☐ Yes 2 No	Specify:	, Puerto Rican, etc.)		Black, White Specify: Whi	, etc.	
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pu	al Hyg I other	Be C	17. Father's Name (First, Middle, Last)			1			r's Name (First, Mide		Sumame)		
Maryland	Menta	7	John Seymour Moo						A. Blanch				_
<u>a</u>	id 2 sh lth and 27 ie m traum		19a. Informant's Name/Relationship (7) Garven Hudgins Jr				,		r or Rural Route Nui Potomac,				
J.G	of Hear item		20a. Method of Disposition	-	20b.	Place of Dispo	sition (Name of natory or other place	(e)	Date	20c. Lo	ocation - City or T	own, State	
altimore,	Page ment cant: if		1 ☐ Burial 2 X Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify		Ft.	Lincol	ln Cremat	ory 1	0/21/2005			Maryland	
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			23a. Part1. Enter the disease, or companies shock, or heart failure. List only	one cause on e	ach ling.		er the mode of dyin	g, such as	cardiac or respirator	arrest,		Approximate Interval Between Onset and Death	
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ords	w require been sig should b			-					1[☐Yes 2	□ No 3 □ Prot	oably 4 🛣 Unknown	
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a		e Col	25. Was case referred to medical								1 ☐ Yes	2K) No	
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DIVIS	tel or Atte s after de bi Directo ed in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place	of Injury - At h	nome, farm, stre ify)	eet, factory, office		28f. Location City or 1	(Street an Town, State	d Number or Rura)	al Route Number,	
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	vithi To t	Σ	29b. Signature and title of certifier				29c. License				e signed (Month,	* * * * * * * * * * * * * * * * * * * *	
	8	1				00-1	D5456	O		UCTO	ber 18,	2003	
	U		30. Name and address of person who c Sunita Bhogavilli					, #23	0, Towson	, Mar	yland 21	286	
	Sta	_	31. Date filed (Month, Day, Year)	32/A	egistrar's Sign		reser				-		_
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			State of Maryland / Depa 1- State Amend Item 8 per informant G862/2/	irtment of Health and M tilicate 95 Death		2005	35860
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Je'Nay Hamilton		October 1		5:45a м
	Examin	er	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital	4b. City, Town, or Location of Death Takoma Park		4c. County of Death Montgomer	~v
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth 8	_	•
Ľ	Director		578-06-9160 1□M 2 ^X F 39 Yrs.	Months Days Hours Min.	ept. 183, Y	-21-1966 irthpl	York
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	th with	ai D	11505 White Oak Vista Terrace	20904		United Sta	ites
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36	within 72 hours after death with the Maryland ene. than "natural", or itams 23e or 28e-f show he Madical Examinar must be notified at	by Funeral Director	1 ☐ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	☐ Yes 2☐ No Specify:		Specify: Blac	
21215-0036	2 hou	ted t	15. Decedent's Education 16a. Decedentian 15a. Decedentia	ent's Usual Occupation	161	b. Kind of Business/Ind	
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and	t be fi	Be	17. Father's Name (First, Middle, Last) Gene Anthony Harris		e (First, Middle, Mai Hamilton	iden Sumame)	
Maryland	should nd Me mark matic	ဥ		g Address (Street and Number or Rura		ity or Town State Zin	Cadel
	nd 2 salth ar 27 is			White Oak Vista T			
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Itam 27 is merked othar than "natural; or Itams 23a or 28a-f show any figury or other traumatic event, the Mazical Examination using a notified at anone.		20a. Method of Disposition 20b. Place of Disposition 20b. Place of Disposition cemetary, crem	sition (Name of patory or other place)	Date 200	c. Location - City or Tox	wn, State
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Ball	permit. Depart Import Import Sany in		21. Signature of Funeral Service Liverisee	Name and Address of Facility Alexander SFacility 0538 Mariboro Pike	Funeral I	Homes, P.A.	20747
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Ь	MEAN.		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	1	or respiratory arrest,)	Approximate Interval Between Onset and Death
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2	al or Att after d Diract d in by	Certification:	4 Homicide determined building, etc. (Specify)	et, factory, office	City or Town, S	t and Number or Rural tate)	Houle Number,
	A Hospital 24 hours a Funaral etely filled		29a. Certifier E Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place,	and due to the cause	e(s) and manner as sta	ited.
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	vithin To the comple	2	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, D	ay, Year)
	(5)			5614	/	10/20	101
U			30. Name and address of person who completed cause of death (Item 23a) (Type, P	CARROLL AVE.	TAKAN	a bool	M/ 209/1
	Sta	te	31. Date filed (Month, Day, Year) 7. Registrar's Signature	CANCUIT ITVE.	177101	IM IHKK	1.0.
	Registr	_	31. Date filed (Month, Day, Year) OCT 2 1 2005 Registrar's Signature	E)			

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	Physici		1. Decedent's Name (First, Middle, Last)			Day Year 3. Time of Death
	/Medio Examir		PLANTISTA B. HAWKINS 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea	OCTOBER 1	9, 2005 10:20P M
	Funeral Director		HEARTLAND HEALTH CARE AND REHAB 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 578 48 9565 1 □ M XIXF 68 Yrs.	ADELPHI	s. 8. Date of Birth	PRINCE GEORGES 9. Birthplace (State or Foreign Country)
	land bw		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I.	Location		10d. Inside City Limits
	Mary B-f sho	tor	MARYLAND PRINCE GEORGES FAIRMONT	HEIGHTS		XXYes 2 □ No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	eath v		5433 SHERIFF ROAD 11. Marital Status 12. Was Decedent Ever in U.S. 13	20743		NITED STATES
036	ours after d ral', or Item Erain in f	by Funeral	1 Never Married 2 Married 1 Never Married 2 Married XX Widowed 4 Divorced 12 Was Deceding Cert in 0.5. 13 Armed Forces? 1 Yes A No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (: If Yes, specify Cuban, Mexican, Puel 1 Yes XX No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK
21215-0036	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or Items 23s. or 28s-f show marked other than "natural", or Items 23s. or 28s-f show marked other the Medical Exam in Finial Lexical Institute at all the standard at the contribute of the co	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation le kind of work done during most of wo DO NOT use retired)	orking	. Kind of Business/Industry
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<u>Iar</u>	should be nd Mental marked o umatic ave	ToB	WILLIAM LEE	HENRIET	TA HACKNEY	
Maryland	l 2 sho and l			ling Address (Street and Number or R		
	s 1 and 2 should if Health and Men item 27 is marke other traumatic		20a. Method of Disposition 20b. Place of Disp	ELKWOOD LANE #30		HEIGHTS, MD 20743
ē	m O		Burial 2 Cremation 3 Removal from State	ematory`or other place) VETERANS CEM. 10/		HELTENHAM, MD
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Foneral Service Licensee	22. Name and Address of Eacility IARSHALL SFUNERAL	HOME OF M	ARYLAND, INC.
	402 0 0		23a. Part / Enter the disease, or complications that caused the death. Do not en shock or heart failure. List only one cause on each line.	308 SUITLAND ROAD	SUITLAN	D, MD 20746 Approximate
	/Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death) a. ATHEROSCLEROTIC Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			Interval Between Onset and Death
O. BOX 68/6U,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medical Ey	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3[□Ectopic pregnancy □ Other (<i>specify</i>)		23d. Date of delivery Month Day Year
cords, P.	es pe	by	Part II. Other significant conditions contributing to death but not resulting in the CEREBROVASCULAR ACCIDENT, PERIPHERAL			o use contribute to the cause of death? XXNo 3 □ Probably 4 □Unknown
H H	The law ate has b page 2 st	Completed	END STAGE RENAL DISEASE, FAILURE TO	<u> </u>	24a. Was an autopsy performed 1 Yes XXX	
VII	Physician: Th this certificate al director, pag	o Be	25. Was case referred to medical examiner? Hospital: Hospital:	0.1	ath Check only one)	
		\vdash	1 Yes XX No	ALANUISING F	Home 5 Residence 28d. Describe how in	
DIVIS	To the Hospital or Attanding within 24 hours after death. To the Funeral Diractor: Atter completely filled in by the tune	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, te)
	To the Hospital within 24 hours and to the Funeral completely filled	Medical	29a. Certifier (Check only one) XXX Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.			Trapiaco, and data to the basse(s)
	70 Cor		29b. Signature and title of certifier Acris V Acris Smitams	29c. License number		Date signed (Month, Day, Year)
		-	30. Name and address of person who completed cause of death (Item 23a) (Type,	D30770	OC	TOBER 21, 2005
			DORIS V. PABLO-BUSTOS, M.D. 116	50 VARNUM ST. NE	213 WASHI	NGTON, DC 20017
	Sta Registra	3.	31. Date filed (Month, Day, Year) 2. Registrar's Signature	J.		

State of Maryland / Department of Health and Mental Hygie 0 5 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCTOBER 15, **Physician** WILLIAM HARDING HILL 7:20P M 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** VILLA ROSA NURSING HOME MITCHELLVILLE PRINCE GEORGES 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Hours XXM 2 F Yrs. Director SEP. 16, 1921 <u>250 26 3367</u> 84 SOUTH CAROLINA Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Director XX Yes 2 □ No PRINCE GEORGES GREENBELT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or Items 23g 7812 HANOVER PARKWAY #202 20770 UNITED STATES death Funeral 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 □ No 1943-11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No If Yes, Give Year or Dates: by Specify: BLACK 3 Widowed 4 Divorced naturel 1946 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Importent: If item 27 is marked other th any injury or other treumatic event, I'ms once. 12TH AGRICULTURAL SPECIALIST PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ HOMER HILL MELLIE HILL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANCES A. HILL / WIFE 7812 HANOVER PARKWAY #202 GREENBELT, MD 20770 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State '4 □Donation 5 □Other (Specify)

21. Signature of runeral Service Accesses FT. LINCOLN CEMETERY | 10/21/2005 BRENTWOOD, MD MARSHALL STRUMERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final disease condition resulting in death) Prosician HYPERTENSIVE CARDIOVASCULAR DISEASE YEARS /Medical Due to (or as a consequence of): Examiner DIABETES MELLITUS YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner sician and burial-transit The law requires that the death certificate be executed SEVERE DEMENTIA YEARS Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) Records. P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes XX No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform of Vital 1 ☐ Yes XXNo 1 Yes 2□ No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: XX Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes XXNo 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Division Injury XXNatural 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAKESH ARORA, M.D. 14300 GALLANT FOX LN. #222 BOWIE, MD 20715 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

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d	Item	2State of	Maryland / D per me G84	epartment of H	lealth and Mental	HygieRe() () 5	358	36	3

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· >			1. Decedent's Name (First, Middle, La					2. Date of De	ath		3. Time of Death	_
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	Examir		4a. Facility Name (If not institution, give	re street and number)			or Location of Death	1	4c. County			-
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	Funeral		577 70 0010	I M SINE	rs. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bir (Month, Da	ay, Year)	Cour	place (State or Foreig	
	Director		Usual Residence of Decedent	53	115.			Aug. 27	1952	Washi	ngton, DC	
	laryland show		10a. State 10b. County	10c.	City, Town or Lo	ocation				1	0d. Inside City Limits	-
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	r 288	Directo	10e. Street and Number		, 4000 123	10f. Zip Code			10g. Citizen of V	Vhat Cour	ntry?	-
	h with		6800 Farragut St.			20	784		U.S.	٨		
	deal ma	Funerai	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.		Hispanic Origin? (Si pan, Mexican, Puert	pecify Yes or No	- 14. Race	e - Americ	an Indian,	-
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. Vd other than "natural", or Items 23a or 28a-1 show event, I're Medical Examiner must be traitlist at	by	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2X No		o rican, etc.)		Blac		
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pu	should be filed withir nd Mental Hygiene. marked other than imatic event, It's M.	Be	17. Father's Name (First, Middle, Last,)					, Maiden Sumam	θ)		
7	should be nd Mental marked o umatic eve	은	Walter Williams	-			Roselil1					
Maryland	2 2 2 2		19a. Informant's Name/Relationship (Randy Holley/Hush	**			t and Number or Ru				Code)	
	is 1 and of Health item 27 other tr		20a. Method of Disposition		. Place of Dispo		St. Hyat	Date	MD ZU / 20c. Location -		State awa	_
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Baltimore,	permit. Pages Department of Important: If i sny Injury or o		21. Signature of Funeral Service Lices				etery 10/2			-		_
B	permit. Departr Imports sny Inji		Van 4 H.	11.	1		ensburg Rd					
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	Physician		shock, or heart failure. List only Immediate Cause (Final		Comd		Di				Interval Between Onset and Death	
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Δ.	requires that the death been signed by the atter hould be detached for u	by P	Part II. Other significant conditions of	ontributing to death but not re	esulting in the ur	nderlying cause gr	ven in Part I.	23e. Did to	bacco use contri	bute to the	e cause of death?	_
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<u>a</u>	ian: T	0	25. Was case referred to medical				26. Place of Deat	h (Chack agiv a		Yes	2 □ No	
<u> </u>	nysic iis ce direc	ToB	examiner? 1X☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2	☑ ER/Outpatien	t 3 DOA Ott			dence 6 □Othe	r (Specify	1	
0			27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injui			now injury occurre		/	
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É	after death after death Director: Jin by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre cify)	eet, factory, office		28f. Location (S City or Tow	Street and Numbe m, State)	r or Rural	Route Number,	_
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	ledical C	29a. Certifier (Check only one)	ysician: To the best of my kinner: On the basis of examinand and manner stated.	nowledge, death nation and/or inv	occurred at the til	me, date and place, ppinion, death occur	and due to the or	cause(s) and mar date and place, a	ner as sta	ated. the cause(s)	_
	To the Within To the comple	Me	29b. Signature and title of certifier	and mainter stated.		29c. Licens	number		29d. Date signed	(Month, E	Pay, Year)	-
•			Yanet Four	Half, no				(October 2	23, 2	005	
AM			30. Name and address of person who	completed cause of death (Its		Print) 111 F	Penn Stree	et Balt	imore, M	lary1	and 21201	_

Registrar

DHMH 17 Rev 1/2001

State gistrar 31. Date filed (Month, Day, Year) QCT 2 8 2005

32. Registrar's Signature

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

OCT 2 1 2005

State of Maryland / Department of Health and Mental Hygiepe 05 35865 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 2Ź, October 2005 4:02 A M Andrew Johnson Roger /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Howard Fulton 12412 Hall Shop Road 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 1 M 2 ☐ F 9. Birthplace (State or Foreign Country) South Dakota 5. Social Security Number 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min. 503-16-1392 84 Yrs. Mar 5, Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral', or items 23a or 28e-f show Examiner must be notified at 1 Yes 2 No Maryland Howard Fulton Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20759 USA 12412 Hall Shop Road Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WW I I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ 3

Widowed 4 □ Divorced of other than "natural", event, the Madical Ex-Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Federal Government 12 Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ith and Mental F 27 Is marked of treumetic ever Andrew Oscar Johnson Lura Louise Rogers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Importent: If Item 27 Is any injury or other treu once. 1080 Fannie Nicholson Road Charmansboro, TN Constance J. Johnson/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition October 24 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2005 W. Arundel Crematory Odenton, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 MO1251Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Mon Small Cell Long Cancer 5 +138 TT 25 minths /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) -transit The law equires that the death certificate be executed Due to (or as a consequence of): physician ar Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Ö 9 Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Radiation Paromonitis 1 Ses 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 █ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Plaurisy Malignant page 2 s has ertificate Division of Vital To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) After this 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours after To the Funerel Dire 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 030573 October 24, 2005 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) , MO 11065 Little Patoxint Parkway, Columbia MO 21044 ford N 12 32 pistrar's Signature 31. Date filed (Month, Day, Year) State OCT 25 2005 Registrar

			1 - State of Maryland /	Depa Cei	artment of H	ealth and Death	1	Reg. No.	005	35866
	Physici	an	1. Decedent's Name <i>(First, Middle,</i> Last) BEVERONE ANN JOHNSON				2. Date of De.	ath Day	Year	3. Time of Death
,	/Medic Examin		4a. Facility Name (If not institution, give street and number) Doctors Hospital		4b. City, Town, or Lanham	Location of De		4c.	2005 County of Death cince Ge	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last		If Under 1 Year Months Days	If Under 24 H Hours M		th v. Year)	9. Birth	place (State or Foreign
	Director		219-64-9414 1	Yrs.			9/1/19			ginia
	anyland show		10a. State 10b. County 10c. City, To	own or Lo	cation					10d. Inside City Limits
	8e-f s	Director	MD Prince George Glena	rden						1 ∑ Yes 2 □ No
	death with the Maryland ms 23a or 28e-f show frives be neithed at		10e. Street and Number		10f. Zip Code 20706			10g. Citi:	zen of What Cou	ntry?
	death	Funerai	8710 McLain Avenue 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13.1	Was Decedent of Hi	spanic Origin?	(Specify Yes or No		14. Race - Ameri	
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and		To Be	Peter Hill.Jr.				lame (First, Middle, D. Rose	Maiden	Sumame)	
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χ. Σ	and 2 lealth m 27 I	}				Lane,	Baltimore			
20	Pages 1 nent of H int: If its iry or ot		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	etery, cren	sition (Name of natory or other place	· 1	Date		cation - City or T	
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מ	Physician		23a. Part Enter the disease, or complications that caused the death. E thook or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition			g, such as card	liac or respiratory ar	rrest,		Approximate Intervat Between Onset and Death
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	ysicia is certi directo	0 B	examiner?	Outpatier	it 3□ DOA Othe		Death Check only on the side of the side o	-7.	□Other (Speci	(v)
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INISION	I or Attendi after death. Director: A I in by the fu	icati	2 Accident investigation 3 Suicide 6 Could not be	farm etc		res 2 □No	29f Location /6	Stroot 2 mg	Alumbar or Rus	al Paula Number
2	To the Hospital or Attending Physician: within 24 hours after deals. To the Funerel Director: After this certific completely filled in by the funeral director,	Certification:	4 Homicide determined 28e. Place of Injury - At home building, etc. (Specify)				City or Tow	vn, State)		al Route Number,
	e Hosp 24 hou e Fune letely fil	edical	29a. Certifier (Check only one) (Check one) (Ch	ige, death and/or inv	n occurred at the time vestigation, in my op	e, date and pla pinion, death oc	ice, and due to the occurred at the time,	cause(s) date and	and manner as s place, and due to	stated. o the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier		29c. License				signed (Month,	
0	C		h Mahad fage			05286	0.5	19	-17-	1002
6	(D)		30. Name and address of person who completed cause of death (Item 23			/N/ 2.	Wille MI) an	720	
	Sta	te	KELSON M. FICARO 7502 O 31. Date filed (Month, Day Year) OCT. 2 1 2005 OCT. 2 1 2005	DISIN	DEERY W	HY DE	JUIE, FIL	00		
	Registr	ar	UCIER I COUS JOHN IN 19							

State of Maryland / Department of Health and Mental Hygiene 15 Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Charles Marvin King Jr Nov $\boldsymbol{a}^{\mathsf{M}}$ 2005 1:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbert Memorial Hospital Prince Frederick Calvert If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Fe (100nth 102y, Year) 9. Birthplace (State or Foreign Was Single), DC 7. Age (In yrs. last birthday) 80 Yrs. 5. Social Security Number **Funeral** 1**X**]M 2□F 579-16-2588 Yrs. Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 2 should be filed within review and Mental Hygiene.

'Is marked other then "netural", or items 23s or 28s-f show with event, the Medical Examiner must be notified at 10d. Inside City Limits MD Calvert Prince Frederick Director 1 Yes 2/0/No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 125 Allnutt Court #312 20678 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ 3 Widowed 4 XDivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Grocery Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Marvin King Sr Pearl ELizabeth Belew 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Justin Michaud Great Grandson 209 Friendship Rd Friendship,MD 20758 Health tem 27 I 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages nent of hant: if ite 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. Mount Comfort Cem. 11/4/05 Fairfax Co., VA 4 □ Donation 5 □ Other (Specify) 21. Signature of Fur stal Service Licensee Cunningham Fatuneral Home abu 811 Cameron St Alexandria, VA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Vallalar e/101-1 /Medical Due to (or as a consequence of): Examiner A & (~)
Due to (or as a consequence of Securitally list out differs if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a sequence of) burial-t Division of Vital Records, P.O. Box 68760, inding physicien use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atter for 1 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Hinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has autopsy performed? res 2 100 certificate 1 ☐ Yes 2 ☐ No 1 Yes Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ို 1 Impatient 2 ER/Outpatient 3 DOA this : After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No death. hours efter death unaral Director: 2 Accident the Vithin 24 hours enc.
To the Funarat Director:

To the Funarat Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the date (s) and manner as etated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00061947 -1/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr mang Mathur 100 Hospital Rd. Prince Frederick, MD 20678 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiefe

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	_	1 - State Registrar			Cer	tificat	e of L	Death		,	Reg. No.		00000
Physici	an	Decedent's Name (First, Middle, La. TO ANN								2. Date of De Month		Year	3. Time of Death
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138; ·	No.	Frederick Memoria 5. Social Security Number 6. S			st birthday)		deri 1 Year	Ck If Under:	24 Hrs. 8	3. Date of Bir	th F	rederick	pplace (State or Foreign
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a-fe	ctor	Maryland Frederi	ck	Thu	rmont								1 ☐ Yes 2 ☑ No
다 다 0 28	Director	10e. Street and Number				10f. Zip	Code				10g. Citi	zen of What Cou	untry?
ath w	rai	8126 Rocky Ridge					217					USA	
item item	Funerai	11. Marital Status 1 ☐ Never Married 2 ★ Married	12. Was Decedent E Armed Forces? 1 Tyes 25 No		i. 13. V	Yas Deced Yes, spec	dent of Hi cify Cuba	n, Mexican	gin? (Spec 1, Puerto R	ify Yes or No ican, etc.))-	 Race - Amer Black, White 	
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led w		47 Fellende Nome (First Middle I act	4		Medic	cal T	echn			Circl Middle		edical	
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should ind Men	10	19a. Informant's Name/Relationship (Joinne	<u> </u>	a Address	(Street a		relyn er or Bural	Route Numb		icholsor r Town, State, Z	
ges 1 and 2 should be filed within 72 hours after death with the Maryla ges 1 and 2 should be filed within 72 hours after death with the Maryla to file than Mental Hygiene. If item 27 is marked other than "neturel", or items 23a or 28a-f show or other treumatic event, the Medical Exprinter must be could at		Raymond E. Kidwe										MD 2178	
S 1 a lifem other		20a. Method of Disposition		20b. Pla	ace of Dispo: metery, crem	sition (Nar	ne of	(A)	Da	te	20c. Lo	cation - City or 1	Town, State
mit. Pages partment of I portant: if its y injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif						1	.0/ 24	/2005	Fre	ederick,	MD
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rth. :: After	inol.	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day)	Year)	28b. Time of Injury	м	28c. Injun Worl	yat k? Yes 2.⊟		3d. Describe	how injur	y occurred	
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of or Atternation of the Control of	Certificati	4 Homicide	building, etc	. (Specify))					City or To	wn, State)	
UNISION OF VITAINECOLOS, F.O. BOX To the Hospitel or Attending Physicien: The law requires that the death certwithin 24 hours effer death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	edical C	29a. Certifier 1 Certifying Pl (Check only one) Medical Example	nysician: To the best of miner: On the basis of and manner state	examinati	vledge, death	occurred estigation	at the tin	ne, date an pinion, dea	nd place, ar ath occurred	nd due to the d at the time,	cause(s) date and	and manner as I place, and due	stated. to the cause(s)
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F > F 0		> X skell.	Taymar	~		1:	1)-	-/3	971	/	10	1/19/0	25
10		30. Name and address of person who	completed cause of de	ath (Item	23a) (Type,	Print)		, ,			-		
, , , ,		Dr. Robert Kauf				nth S	tree	t, Fr	ederi	lck, M	217	702	
Sta Regist	ate	31. Date filed (Month, Day, Year) OCT 2:5 2	32. Jegistra	ir's Signati	k A	and!	,						
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Physi	cian	1. Decedent's Name (First, Middle, La	st)				2. Date of De Month	0	Year	3. Time of Death
/Med	lical	Charlotte			T 41 O't T-		October of Death	20,	2005	12:20P M
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Funera	1	5. Social Security Number 6. S		(In yrs. last birthday)	If Under 1 Ye Months Da	ar If Under				nhplace (State or Foreign
Directo		Usual Residence of Decedent	□м ЖП 8(O Yrs.	Months Da	ys Hours	Min. Sept 28	, 192	5 M	assachusetts
yland how		10a. State 10b. County		10c. City, Town or Le	ocation					10d. Inside City Limits
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3a or 2	Funeral Director	1111 University	Blvd. W #21	15	10f. Zip Cod 20902				n of What C ed Sta	•
eme 2	ner	11. Maritat Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent	of Hispanic Orig	gin? (Specify Yes or No , Puerto Rican, etc.)	- 14		erican Indian,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural; or Iteme 23a or 28a-f show any Injury or other treumatic event, the Medical Examinar must be notified at	by Fu	1 ☐ Never Married 21 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates:		1 ☐ Yes 21 1		, radio riidan, sic.,	Sį	Black, Whi Dec <i>ify:</i> Wh	nite
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Hygi other	Be Co	17. Father's Name (First, Middle, Last,)			18. Mothe	r's Name (First, Middle,			
uld be Menta rrked ritic ev	To B	Joseph Goodman				Beat	rice Alper	t		
d 2 sho th and 7 is mu treum	34	19a. Informant's Name/Relationship (Marvin Konick (H	Type, Print) usband)				r or Rural Route Numb			20002
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he death certifica the attending phy ched for use as th	Physician/Medical	in the past 12-months? 1 Yes 24 No 9 Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	⊒Ectopic pregna ⊒ Other (specify			230	Month	Day Year
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To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edicai C	29a. Certifier 1 Certifying Pr	nysician: To the best of niner: On the basis of e	xamination and/or in	th occurred at the	e time, date and ny opinion, deat	d place, and due to the th occurred at the time,	cause(s) an date and pl	d manner a	s stated. e to the cause(s)
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To the within 2 To the complet		and M	16 1		100.	,,,,		OCLO	DEL Z	0, 2005

State of Maryland / Department of Health and Mental Hygiepe 15 35870 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death October 19, 2005 **Physician** 6:30 P M Etta Dratt Klett /Medical 4b. City. Town, or Location of Death 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Potomac Rebecca House Group Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplece (State or Foreign Months | Days | Hours | Min. | September 11,1909 | NY 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 🗆 M 96 Director 105-01-2028 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rithen "natural", or items 23a or 28a-f show the Medical Examiner must be nutified at 1 Yes 2 No Director Potomac Maryland Montogomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S. of A. 20854 9910 River Road death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ★ M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or iten important: if Item 27 is marked other than "natural", or iten eny injury or other treumatic event, the Medical Examina once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White φ XiX Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Cary A. Harris Edgar Dratt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code)
1516 Victoria Farms Lane Vienna, VA 22182 19a. Informant's Name/Relationship (Type, Print) Mr. Dave Zehr Klett , Son Oct. 22 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Chestnut Grove Cemetery Herndon, Virginia 2005 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudoun Funeral Chapel, Inc. William 158 Catoctin Circle, SE 20175 Leesburg, VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failates. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 Wo
9 Unknown Year Month Day 4☐Pregnant at time of death 5 Other (specify) detached the 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death bull not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 Unknown 1 Yes 2 No Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ☐ 2 ☐ No 24a. Was an has page 2 autopsy performa certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🗌 Inpatieni 2 ER/Outpatient 3 DOA 2 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \ Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maryland 20855 6001 Muncaster Mill Road Rockville. Charles Harrison M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 Registrar

	For State Registrar	State of Ma	aryland / Depa	artment of H	lealth and M Death		iene	5 3	35871
	1. Decedent's Name (First, Middle, L	ast)				2. Date of Death	h Day	Vana	3. Time of Death
Physician /Medica	LUUIS	М.	LIE	В		OCT.	19	Year 2005	9:55 A M
Examine		ive street and number)		4b. City, Town, or	Location of Death		4c. Count	y of Death	
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Funeral	Social Security Number 6.	Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, DEC • 18,	Year)	9. Birthpi	ace (State or Foreign
Director	579-05-9196	TIZEM ZLIF	86 Yrs.			DEC. 18,	1918	D	•C •
N pg ≥	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				11	Od. Inside City Limits
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Ne Ne Ne Ne Ne Ne Ne Ne Ne Ne Ne Ne Ne N	DELAWARE SUSSE	X	FENWIC.	K ISLAND					
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ter d	1	Armed Forces?		f Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)		ce - America Ick, White, 6	
)36 irs at	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give		1 ☐ Yes 2 🛣 No	Specify:		Specil	fy: WH	ITE
id 21215-0036 Id 21215-0036 Id 21215-0036 Illid within 72 hours after death with the Marylar Hyglene. Other than "natural", or liams 23a or 28a-f show ant, if a Marylar Examinar matter multified at	15. Decedent's	Education	16a. Deced	dent's Usual Occupa	ation		16b. Kind of E		
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Maryland Maryland d 2 should be file th and Manial Hy 77 is marked oth traumatic evant	BERNARD	J. L.	IEB		FLORE	NCE	M	IcMAH0	N
Tary lary and h	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street a	and Number or Rura	al Route Number,	City or Town	, State, Zip	Code)
, c = 0 =	PAULINE LIEB/WIF	E	RT. 3	BOX 223	, FENWICK	ISLAND,	DE. 1	9944	
3 - 0 0	20a. Method of Disposition		20b. Place of Dispo	sition (Name of natory or other place	(e)	Date 2	20c. Location	- City or To	wn, State
eb, Lour Styll Description of the permit Pages Department of Important: If it is any injury or on one	1 X Burial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spec		DELAWARE			/24/05	MILLS	BORO,	DELAWARE
Balti Balti Bermit. Depart Importe any inji	21. Signature of Theral Service Lic	ens e	22	. Name and Addres	ss of Facility				
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	23a. Part1 Enter the disease, or co shock, or heart failure. List on	mplications that causely one cause	e death. Do not ent	er the mode of dyin	g, such as cardiac o	or respiratory arre	st,		Approximate Interval Between
Physician	Immediate Cause (Final disease or condition	Rial	1 1	na C	2000	0		- 1	Onset and Death
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68 rtiffica	JE TECHNIC		-						
Box eath cert attending for use a	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth		Ectopic pregnancy				te of deliver	
B. E s dea	in the past 12 months?	4 ☐ Pregnant at 9 ☐ Unknown		Other (specify)			Mo	onth I	Day Year
P.O. hat the de d by the setached	9 □ Unknown								
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lawr lawr 2 sh						24a. Was an autopsy	24b.	Were autop	sy findings available upletion of cause of
						perform	led?	death?	2□ No
Vital Rec					26. Place of Death				
hysice his ce	1 Yes 2 No	Hospital: 1 Inpatie	ent 2 SER/Outpatien	t 3 DOA Othe	er: 4 🗆 Nursing Ho	me 5 🗆 Resider	nce 6 Oth	ner (Specify,)
ng Pl		28a. Date of Inju (Month, Da	ry 28b. Time of Injury	28c. Injury Work	/ at c?	28d. Describe how	w injury occur	red	
SiOl andii sath. or: A he fu	2 Accident investigati	ion			Yes 2□No				
Division of Vital Records, tal or Attanding Physician: The law requires the stater death. al Director: After this certificate has been signed in by the funeral director, page 2 should be considered.	3 Suicide 6 Could not 4 Homicide determine	28e. Place of Injude	ury - At home, farm, stre c. (Specify)	eet, factory, office	:	28f. Location (Str. City or Town,	eet and Numt State)	ber or Rural	Route Number,
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Division of Vital To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Director: After this certifical completely filled in by the funeral director.	29a. Certifier 1 Certifying I (Check only 2 Indical Expone)	Physician: To the best aminer: On the basis of and manner sta	f examination and/or inv	occurred at the time restigation, in my op-	ne, date and place, a pinion, death occurr	and due to the cared at the time, da	use(s) and ma te and place,	anner as sta and due to	ited. the cause(s)
To the within To the comp	29b. Signature and title of certifier	- MINH	7	29c. License	a number	29	d. Date signe	d (Month, D	Pay, Year)
4.	→ / ' ∨ /	M		100	(733)	3	101	20/	0
Z Z	30. Name and address of person wh	o completed cause of d	leath (Item 23a) (Type,	Print) P.J.	MEHTI	7, m. L	7.		<u> </u>
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Registra	OCT 2 4	2005	1. K. A.	- A A B B			_		

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 35872 = State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** . 2005 October 23, 1:15 A Gregory Robinson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Southern Maryland Hospital Center Clinton If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, April 13, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F 75 Yrs. Director 230-30-5900 Virginia Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or items 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yes 2√√No Directo Maryland Prince George's Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2302 Steuben Avenue 20744 Funeral filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Marned 1951-Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2X No þ Specify: Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DQ NOT use retired) Human Resource Supervisor 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Personnel other then Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if item 27 is marked other any injury or other traumatic event, since. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Warren Lee Minnie B. Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2302 Steuben Avenue Ft. Washington, Maryland 20744 Elizabeth Lee / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Md. Veterans Cemetery Cheltenham, Maryland Oct.28,2005 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home PA Juneral Service bicenses 21. Signature 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part I Interthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ance -UN0 /Medical Due to (or as a consequ Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires thet the death certificate be executed Due to (or as a consequence of): Box 68760. Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? 1 Yes 3 Probably 4 Unknown 2 No 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 20 No after death.

Director: After this certification in by the funeral director, in 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospital o within 24 hours aft to the Funerel Di completely filled in Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medicai and manner stated ertifier 29c. License number 29b. Signature and fitte of 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd. Ft Washing ton 11701 Livingston CATLOUNE CAINE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 2 4 2005 Registrar

			1 - For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of H rtificate of L			ene 0 0	5 35873
	Physici /Medio		Decedent's Name (First, Middle, Last) F'RANK	CHESTER	LAZARSKI			2. Date of Death Month October	Day	3. Time of Death
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	Funeral Director	*	0/9-10-0/00		(In yrs. last birthday) 85 Yrs.	Frederi If Under 1 Year Months Days		8. Date of Birth (Month, Day, Nov. 3,		erick 9. Birthplace (State or Foreign Country) New York
1,1000	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
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	th the	Director	10e. Street and Number		Trederi	10f. Zip Code		10	g. Citizen of Wh	nat Country?
	ath wi	rai	700 Toll House Ave	nue		21701		Ur	nited St	ates
980	72 hours after death with the Maryland natural', or Items 23a or 28a-f ehow Alcel Exactinat must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2反 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates:	1	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Spin, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black,	- American Indian, White, etc. White
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Maryland			19a. Informant's Name/Relationship (Ty	A.	The same of	ng Address (Street a			•	
altimore, I	Pages 1 and 2 should nent of Health and Men int: If Item 27 is marke iry or other traumatic		Thomas Lazarskí / 20a Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)		120b. Place of Dispo	natory or other place	Oct.	26,	0c. Location - C	ity or Town, State
Balti	permit. Pag Department Important: I eny Injury o		21. Signature of Fun, al Service Leading		R.	Name and Addreses	s of Facility Funeral S	ervices,	Skkot	Maryland Cody P.A.
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٥	Tha law requires that the de Ite has been signed by the z vaga 2 should be detached i	by	Part II. Other significant conditions cor	tributing to death but	not resulting in the ur	nderlying cause give	on in Part I.		cco use contrib	ute to the cause of death?
of Vital Records,		Completed						24a. Was an autopsy performe 1 Yes 2	ed? dea	ere autopsy findings available or to completion of cause of ath? I Yes 200 No
Vit	Physician: this certifica ral director, p	o Be	25. Was case referred to medical examiner?	ospital:	2 ER/Outpatien	Othe	26. Place of Death			
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	Alli		Smy	mo	IND	\mathcal{D}	2834	1	10-2	20-05
T	7/14		30. Name and address of person who co	212, M	D 80	Print) 1 Tu	llHon	re Am	2, Free	deriel, MO
7	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 5 20	32. Registrar	's Signature	parte				21701

			For State Registrar	State of I	Maryland / I		rtment of				iene	5 3	358	74
			1. Decedent's Name (First, Middle, La.	st)					2	. Date of Deat	h		3. Time of	f Death
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}	Examin		4a. Facility Name (If not institution, give				4b. City, Town	n, or Locati		00000	4c. County		0.55	
			3907 Lawrence A	venue			Kensin	gton			Montgo	merv	r	
	Funeral		5. Social Security Number 6. S	өх 7.	Age (In yrs. last bi	irthday)_	If Under 1 Ye	ar If Un	der 24 Hrs. 8	. Date of Birth		9. Birthp	lace (State o	or Foreign
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	show	_	10a. State 10b. County		10c. City, Tov	wn or Loc	ation					1	0d. Inside C	
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	or 24	Director	10e. Street and Number			- 7.	10f. Zip Cod	le		1	0g. Citizen of W	hat Cour	ntry?	
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36	or It	y F.	1 Never Married 2 Married	1 ☐ Yes 2 If Yes, Give	₩ No		☐ Yes 2451			, , , ,	Specify.		610.	
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of \	Physic this co	2	1 ☐ Yes 2 🔀 No	Hospital: 1 🗌 Inpa		utpatient	3□ DOA	Other: 4 [Nursing Home	5 ∑ Reside	nce 6 Othe	r (Specify	1)	
		:uo	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of It	njury 28b. Day Year)	Time of Injury	28c. lr	njury at Work?	28	d. Describe ho	w injury occurre	d		
Si	Attanding r death. sctor: After y the fune	ati	2 ☐ Accident investigation					Yes 2	No					
Division	or Att	ertification:	3 Suicide 6 Could not be determined	286. Place of	Injury - At home, fa etc. (Specify)	arm, stre	et, factory, office	ce	28	f. Location (Str City or Town	eet and Numbe State)	r or Rura	/ Route Num	ber,
	ne Hospital or Attandi 124 hours efter death. Ne Funeral Director: A bletely filled in by the fu	O												
	Hospital 24 hours e Funeral C	dical	Check only 2 Medical Exam	ysician: To the be niner: On the basis	st of my knowledges of examination ar	e, death	occurred at the	e time, date	e and place, and	d due to the ca	use(s) and mar	ner as st	ated.	.)
	To the Hospital or At within 24 hours efter of To the Funeral Direct completely filled in by	Medi	3710)	and manner	stated.									,
	To To Con	4	29b. Signature and title of certifier	1		_		ense numb)er	29	d. Date signed	(Month, i	Day, Year)	
,	10		4,000 U	12	/	ng	DF09	9577			10/18/	2005	i	
			30. Name and address of person who Dr Richard Pollen	completed cause o	death (Item 23a)	(Type, P	Print)	16 17			0005			
			Dr Richard Pollen 31. Date filed (Month, Day, Year)					o Ker	usingto	n, MD 2	U895			
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		1- State of I	Maryland / Depa <i>Ce</i>	artment of He rtificate of D	ealth and Me Death	ental Hygie		35875
Physi /Med		Decedent's Name (First, Middle, Last) JANIS L L	ВВУ			2. Date of Death Month DCT, 19,	Day Year 2005	3. Time of Death 5:30 A M
Exam		4a. Facility Name (If not institution, give street and number 8100 CONNECTICUT AVENUE,	•	4b. City, Town, or L CHEVY CH			4c. County of Death	
Funera Directo		5. Social Security Number 043-38-7564 6. Sex 1	Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	3. Date of Birth MAY 8, I	918	place (State or Foreign intry) BAMA
he Maryland 8a-f show	ector	10.00	10c. City, Town or Lo	CHASE				10d. Inside City Limits 1 Yes 2 □ No
ath with the 23s or 2	rai Dire	8100 CONNECTICUT AVENUE,	#1615	10f. Zip Code 20815		"	S.A.	intry?
permit. Pages 1 and 2.8 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, the Medical Evantiest must be to differ an injury or other traumatic event, the Medical Evantiest must be to differ an injury or other traumatic event, the Medical Evantiest must be to differ an injury or other traumatics.	by Fune	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	s? No	Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 No	panic Origin? (Spec , Mexican, Puerto Ri Specify:	ify Yes or No- ican, etc.)	14. Race - Amer Black, White Specify: W	
within 72 ho ene. than "natur	ompleted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4c)	(Give	dent's Usual Occupate hind of work done du DO NOT use retired) MEMAKER	ion iring most of working	161	OWN HO	,
id be filed enta! Hygi ked other c event, I	o Be Co	17. Father's Name (First, Middle, Last) JACOB KAUFMAN			18. Mother's Name (First, Middle, Mai		LEVY
nd 2 should the and M 27 is mark	-	19a. Informant's Name/Relationship (Type, Print) I. LEWIS LIBBY - SON		ng Address (Street an				
bermit. Pages 1 a Department of Hea mportant: If item	В	20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 ☒ Removal from Sta '4 □ Donation 5 □ Other (Specify)	20b. Place of Dispo cemetery, crea		Da	te 200	c. Location - City or T	
permit. Departr Importa	SUCG.	21. Signature of Funeral Service Licenses M009		2. Name and Address		,DIRECTI	ON, INC.	0852
Physiciar /Medica Examine	al	resulting in death i	sed the death. Do not entail the line. PIRATORY ARE as a consequence of):		such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
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icate be executed physician and the burial-transit	dical Ex	Due to (or	as a consequence of):					
The law requires that the death certificate has been signed by the attending roage 2 should be detached for use as	Physician/Me		2 Fetal death 3 at time of death 5	Ectopic pregnancy Other (specify)			23d. Date of delive Month	rery Day Year
w requires that been signed b	b	Part II. Dther significant conditions contributing to death	n but not resulting in the u	inderlying cause given	in Part I.	23e. Did tobac	co use contribute to 2 √No 3 □ Pro	the cause of death?
ding Physician: The law r n, After this certificate has be tuneral director, page 2 sh	e Completed	25. Was case referred to medical				24a. Was an autopsy performed	prior to co death?	opsy findings available ompletion of cause of 2 No
Physician: This certifica	To B	examiner? 1 Yes 2 No Hospital: 1 Inpa		nt 3 DOA Other	4 Nursing Home	e 5 Residence	e 6 □Other (Speci	fy)
of attending later death. Director: After d in by the funer	Certification:	1 X Natural 5 Pending (Month, 2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of	Day Year) Injury Injury - At home, farm, str	M 1 ☐ Ye	es 2 No	d. Describe how i	t and Number or Rur	al Route Number,
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.		29a. Certifier 1 Certifying Physician: To the be	s of examination and/or in	h occurred at the time	, date and place, an	d due to the caus	e(s) and manner as	stated.
To the within 2 To the somplet	Medical	one) and manner 29b. Signature and title of certifier	stated.	29c. License			Date signed (Month,	
15		Iffly She	rman	MD 37	059		OCTOBER 2	20, 2005
		30. Name and addless of person who completed cause of			TVED CDDT	NC MADV	T AND 2001	0

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

OCT 2 4 2005

32. Segistrar's Signature

State of Maryland / Department of Health and Mental Hygiene For Stata Registra Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Dav Year Month **Physician** a M 20, 2005 October 8:07 Jacob Crawford Langworthy /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Montgomery Hospice-Casey House Rockville If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthdav) Birthplace (State or Foreign Country) 5. Social Security Number Funeral Months 1**⋈** M 2□F Yrs. Sept. 27, 1928 Indiana Director 090-22-3600 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours alter death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-1 ehow eny Inity or other traumatic event. It a Mudical Evantment must be redifficat 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 ☐ No Silver Spring Maryland Montgomery Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3350 Chiswick Court, 57-2D 20906 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 DYes 2 No If Yes, Give Korean Year or Dates: Conflict 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: White Specify Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Giant Food General Manager 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Rozina Hawkins Elmer Langworthy ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3350 Chiswick Court, 57-2D, Silver Spring, MD 20906 Dorothy B. Langworthy/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition October 24 1 Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 2005 Silver Sp. Mauseleum 2005 Silver Sp. Francis J. Collins Funeral Home Inc. 4 □Donation Stother (Specify) Entombment Silver Spring, Maryland 21. Signature of Funeral Service Licensee Ke 500 University Blvd. W. Silver Spring, MD 20901 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death) Physician Metastatic Non-Small Cell Cancer of Lung /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner anding physician and use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. Š pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🏝 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2**₹** No 1 Yes certificate Division of Vital Hospital or Attending Physician: 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 StOther (Specify) Hospice 1 ☐ Yes 2 ☐ No this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After 5 Pending investigation 1X Natural 1 Tyes 2 No death. 2 Accident Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) tilled in by 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated To the ! 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier. October 20, 2005 10+ W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Charles Harrison, M.d. 6001 Muncaster Mill Road, Rockville, MD 20855 Charles Harrison, M.d. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State OCT 21 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene () () 5 State Registrar Amend Item #2 Per PHY \$9\$10 Gertificate (829ath/17/05 JH Reg. No. 18,2005 2. Date of Death T 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Mariama D. Lumeh October 2005 2130 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Knollwood Manor Nursing Home Millersville Anne Arundel Sterre Tool If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗗 F 347-68-2517 51 Yrs. Director Feb 26. Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show in then "natural", or items 23a or 28a-f show the Medical Examinar must be notified at Yes 2 No Director Maryland Anne Arundel Crownsville 10e. Street and Number 10f. Zip Code 10g. Sitizen of What Country? PO Box 484, 1108 Severnview Drive 21032 Sierre Leone filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ρ 3 Widowed 4 Divorced African Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 4+ Elementary/Secondary (0-12) Registered Nurse Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F Pages 1 and 2 should be Allieu Coomber Feimata Fomba 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a : If itam 27 is or other tra Muanasia Lumeh (Daughter) PO Box 484, 1108 Severnview Drive, Crownsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any Injury or once. Gate of Heaven Cem. 10/29/2005 | Silver Spring, MD 5 ☐ Other (Specify) * 4 Donation 21. Signature Tineral Service Licensee 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Road, Lanham MD 20706 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) METASTATIC Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funarat Director: After this certificate has been signed by the attending physician and completely filled in by the Inneral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Box 68760, Medical Certification; To Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2. No 1 ☐ Yes 2 ☐ No 1 🗌 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number llace in D31136 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KILBRIDE RD, BALTIMORE, MD 21236 MO WALLACE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 2 1 2005 Registrar

CPM 05-07056 Laverne Lewis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Maryla		irtment of H <i>tificate of L</i>			plene 0 0 5	35878
-	Dhuaiai		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month		3. Time of Death
	Physicia /Medic		LAVERNE E.	LEWIS				October		
	Examin	er	4a. Facility Name (If not institution, give s			-	Location of Death		4c. County of Dea	
			Southern Maryland 5. Social Security Number 6. Sex		rs. last birthday)	Clintor	If Under 24 Hrs.	9 Date of Birth	Prince C	
	Funeral Director	g:		IM 2CXF 57	Yrs.	Months Days	Hours Min.	8. Date of Birth November 1	1,1947 Was	thplace (State or Foreign puntry) hington, D.C.
	aryland show dat	_	10a. State 10b. County		City, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	Ba-f	ecto	Maryland Prince Ge	orges Su	itland					- 21
	with ti	급	10e. Street and Number	r 2		10f. Zip Code 20746		1	10g. Citizen of What C	ountry?
	eath ne 23	era	3815 SWANN ROAD #7	L-Z 12. Was Decedent Ever in	11S 13 V	_1	ispanie Origin? (Sp.	acity Vas or No-	U.S. A.	erican Indian
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Itam 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	1 □ Never Married 2 🔀 Marned 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Yes, specify Cuba	ispanic Origin? (Spin, Mexican, Puerto Specify:	Rican, etc.)	Black, Whi Specify: BL	te, etc.
21215-0036	ithin 72 ho ne. nan "natur	Completed by	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give life. L	OO NOT use retired	during most of work	ing	16b. Kind of Business	/Industry
	Hygier Hygier ther th		12		HOMEMA	KER	40.11.1.1.1	(E) . A41.44	PRIVATE	
Maryland	tal H	Be	17. Father's Name (First, Middle, Last) ELSWORTH HAMMOND				AUGUSTIN		Maiden Sumame)	
ž	should be fand Mental I	은	19a. Informant's Name/Relationship (Ty	oe Print)	10h Mailin	a Address (Street			r, City or Town, State,	Zin Code)
	and 2 s ealth an n 27 is:		EDGAR A. LEWIS-HUS	SBAND	3815	SWANN RO	AD #T-2 S	UITLAND	, MD.20746	
Baltimore,	Pages 1 ment of Hi ant: if itar ury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R Donation 5 □ Other (Specify)	emoval from State R	ESSURECT	sition (Name of patory or other place LON	10-22		CLINTON, M	
Balt	permit. Departi	6 B	21. Signature of Funeral Service License	M00	981 PC	PE FUNER			8 MARLBORO	
			23a. Part1. Enter the disease, or complishock, or heart failure. Kist only or	cations hat caused the die cause on each line.	eath. Do not ente	er the mode of dying	g, such as cardiac	or respiratory arr	rest,	Approximate Interval Between
8.2	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons	osckruft	ie Cardi	ovescular	Discus	e	Onset and Death
to.	Examiner	e.	Sequentially list conditions,	Due to (or as a cons	sequence of):					
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Ö,	ificate be executed g physician and as the burial-transit	Exa	resulting in death) Last	Due to (or as a cons	sequence of):					
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P.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
	w requires that been signed b should be deta		Part II. Other significant conditions con Diabetes Mellipus	itributing to death but not	resulting in the ur	nderlying cause give	en in Part I.		bacco use contribute t	1,
I Records,	The law re ate has bei page 2 sho	Completed by						24a. Was a autops perform	sy prior to med? death?	utopsy findings available completion of cause of
/ita	cian: ertific	Be	25. Was case referred to medical examiner?			La	26. Place of Deat	h (Check only or	ne)	
of Vital	Physician: this certificantal director, is	T0	124162 5 140		ER/Outpatien		4 Nuising no		ence 6 Other (Spe	ecity)
uc.	Jing F	ion	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year	28b. Time of Injury	Worl	yat k? Yes 2 □No	28d. Describe h	ow injury occurred	
Division	Attendi death. ctor: A y the fu	Certification:	3 Suicide 6 Could not be	28e. Place of Injury - A	At home, farm, str		100 2 110	28f. Location (S	treet and Number or R	ural Route Number.
Θį	afor after after i Dire	erti	4 Homicide determined	building, etc. (Sp	ecify)			City or Tow		
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funaral Director: After this certificate has completely filled in by the funeral director. page 2	Medical C	29a. Certifier 1 ☐ Certifying Physical Conduction 1 ☐ Certifying Physical Exemination 2 ☑ Medical Exemination (Check only one)	sician: To the best of my ner: On the basis of exam and manner stated.	knowledge, death nination and/or inv	n occurred at the time vestigation, in my of	ne, date and place, pinion, death occur	and due to the cred at the time, d	ause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. License	e number VIE,	2	29d. Date signed (Mon	th, Day, Year)
) ,			+ Hanate Bruth	rll, MO		001			October 18	, 2005
2	(3)		30. Name and ad reg of person who co	impleted cause of death (Item 23a) (Type,	Print) 111 Pe	enn Stree	t Balti	imore, Mary	land 21201
	Sta	ite	31. Date filed (Month, Day, Year)	32 Registrar's Si	gnature					
	Regist		OCT 2 1 2005	Filen	4 los	Le Company				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . ^{Day}2005 October 23, **Physician** Carroll Martin Monroe 8:30 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death 109 Fox Way Oxon Hill Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, April 29, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X**XM 2□ F Baltimore, Maryland 219-10-1312 79 Director Usual Residence of Decedent with the Maryland 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Evant returned to crother at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes XX No Maryland Prince George's Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20745 109 Fox Way LISA by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

122 Yes 2 No 194

If Yes, Give Year or Dates: 1950 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1944-1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎞 No White Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Public Service Aide Sheriff's Office 12 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Isaac Newton Martin Vestah Gay Blackburn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Blanche Martin / Wife 109 Fox Way Oxon Hill, Maryland 20745 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 24 Cremation 3 Removal from State Oct.24, 2005 Kalas Crematory Edgewater, Maryland ⁴ 4 □ Donation 5 Other (Specify) 21. Signature Anneral Service License 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): use as the burial-tran resulting in death) Last Due to (or as a consequence of): signed by the attending physician P.O. Box 68760, death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

AUTICALOSCULAN DUSE 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 99 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page 2 1 Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 → No Hospital: 1 Inpatient Other: 4 Nursing Home 5 \ Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) ospital or Attending Phours after death.
Ineral Director: After t 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗍 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital within 24 hours a To the Funeral C 1 Xertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier dress of person who completed cause of death (Item 23a) (Type, Print) WE CENTER WALDONF, Md. 12010 Registrar's Signature OCT 2 4 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item #18 Per FH C849 11/1/05 JH Death
Per fh,gc,10/31/05 Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Darren Martin OCTOBER 21. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Community Hospital Lanham Prince George's If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1**反**M 2□F Director 217-13-8107 Yrs. 36 Jan 29, 1969 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or flems 23s or 28s-f shovedtes Examiner must be notified at 1 No 2 No Maryland Prince George's Seabrook Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9313 Ogden Place 20706 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No δ Specify 3 ☐ Widowed 4 ☐ Divorced Black Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) Unk unk Unk 17. Father's Name (First, Middle, Last) "Unic 18. Mother's Name (First, Middle, Maiden Sumame) Link Beulah Lee Hines Willis Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Douglas Dawson (Friend) 9313 Ogden Place, Seabrook, MD 20706 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit Pages 1 Department of F 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 10/22/2005 Beltsville, MD 21. Signature Juneral Service Licenses 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Road, Lanham, MD 20706 Enter the disease, ock, or heart failure. L ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the s should be detached 9 Unknown 9 Unknown Part tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 ☐ Yes 24a. Was an autopsy performed 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? page 2 certificate 1 Yes 2 No 1 Yes Attending Physician: director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient No 2 ER/Outpatient 3 DOA this After thi 28c. Injury at Work? 27. Manner of 28a. Date of Injury (Month, Day 28b. Time of Medical Certification: 28d. Describe how injury occurred 5 Pending I Natoral Intury s after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after of To the Funerel Direct 4 Homicide

State Registrar

THOMAS ITAN SSON MD. 31. Date filed (Month, Day, Year) OCT 2 4 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

29a, Certifier

29b. Signature and title of certifier

Harm

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

MDD 53718

575 MAIN STREET SUITE 253 LAUKEL, MD 20707

29d. Date signed (Month, Day, Year)

			1 - State of Maryland State of Maryland	/ Department of H Certificate of L	ealth and Mental Hy Death	giene 005	35881			
			Decedent's Name (First, Middle, Last)		2. Date of D	eath	3. Time of Death			
	Physici /Medic		JOSEPH KELLEY MOORE		OCTOBE!	R 21, 2005	8:27 A M			
>	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or	Location of Death	4c. County of Death				
			BOWIE HEALTH CARE CENTER	BOWIE		PRINCE GEORGE'S				
	Funeral Director		5. Social Security Number 229-54-2341 6. Sex 1	t birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min. ### Min. ### JULY 9	ay, Year) Cou	place (State or Foreign intry) GINIA			
	pue *	}	Usual Residence of Decedent 10a. State 10b. County 10c. City, 7	Town or Location			10d. Inside City Limits			
	faho	5		EWATER			1 ☐ Yes 2 X No			
	28a-	rect	10e. Street and Number	10f. Zip Code		10g. Citizen of What Cou	ntry?			
	3a or	Funeral Director	513 OVERHILL DRIVE	21037		U.S.A.	,			
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9	or its	교	1 Never Married 2 Married 1 No 1 Yes 2 No 1 Yes Give	1 Yes 27 No	Specify:	Black, White				
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ore	ges 1 t of H if ital		1 Burial 2 X Cremation 3 Removal from State	ce of Disposition (Name of netery, crematory or other place	•	20c. Location - City or T	·			
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Bal	permit. Pages 1 and 2 Deportment of Health a Important: If Itam 27 is any injury or other tra <u>QRCB</u> .		21. Signature of Funeral Service Licensee		s of Facility ROBERT E. POLIS ROAD, BOW		AL HOME, 20715			
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	Physician		shock, or heart failure. List only one cause on each line.	Commen	a Artact		Interval Between Onset and Death			
	/Medical		disease or condition resulting in death) a. Due to (or as a conseque	ncerpt):	14 Illian	,				
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	To the Hospital or Attending Phys within 2 hours eiter death. To the Funeral Director: Aflet this completely filled in by the funeral director.	Medicai	29a. Certifier (Check only one) Check only one) Check only one) Check only one)	idge, death occurred at the tim n and/or investigation, in my op	e, date and place, and due to the inion, death occurred at the time,	cause(s) and manner as s date and place, and due t	stated. to the cause(s)			
	ro the	Me	29b. Signature and title of certifier	29c. License	number	29d. Date signed onth,	Day, Year)			
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all	12/11		30. Name and address of person who completed cause of death (Item 23)	3a) (Type, Print)		Joy Og	•			
N.	100	1	JACK R. LICHTENSTEIN, MD, 205 RI		ANNAPOLIS, MARY	ZLAND 21401				
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Baltimore,	permit. Pages Department of Importent: If I any Injury or o		21. Signature of Funeral Service	Licensee	0	, 2	2. Name an	d Addres	s of Facility	y St	tauffe	r Fun	eral I	Home	
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	To the Hospital within 24 hours a To the Funeral I completely filled	Med	29b. Signature and tatle of certifie	and	manner stated.			License					te signed (M		
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	H		30 Name and address of person	who completed	cause of death	(Item 23a) (Type	Print) #	10	ارح				OBER	- 41	C003
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)	Sta Registr		31. Date filed (Month, Day, Year)	5 2005	32. Redistrar's		fra. s	. ,							

			for State Registrar	State of Maryla			nt of He		nd Mei		giene Reg. No.	005	358	85
	Physici /Medic		1. Decedent's Name (First, Middle, Las	ont Mal	in					Date of De. Month		2003		
	Examin	er 	4a. Facility Name (If nbt institution, give University of Mary 5. Social Security Number 6: Se	land Medical 7. Age (In y)	Centers. last birthday,	Bo	r 1 Year	ocation of Under 2 Hours	24 Hrs. 8	Date of Birt (Month, Da	th 1	County of De	ath irthplace (State of Country)	r Foreign
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36	within 72 hours after death with the Maryland liene. r than "natural", or Items 23a or 28s-f ehow the Madical Examilier must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ★Yes 2 □ No If Yes, Give Year or Dates: 194		Was Deci If Yes, sp	edent of Hisp ecify Cuban,		in? (Specif Puerto Ric	y Yes or No an, etc.)			nerican Indian,	
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	item 27		20a. Method of Disposition	20b	Place of Disponentery, cre	osition (Na	ime of		Date				or Town, State	
E C	Page: ent o nt: If		1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		R.A. Feri			1	10/23	/05	West	Chester	, Pennsylv	ania
Baltimore,	permit. Page Department Importent: If any Injury o		21. Signature of Funeral Service Lice	(MENON!	L	ee A.	nd Address Patt ille,	ersor	n & Sc	n Fun 2190	era1 3-07	Home,	P.A.	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	olications that caused the decone cause on each line. a	dem (ter the mo	de of dying,	such as o	cardiac or re	espiratory ai	rrest,		Approximate Interval Betw Onset and D	veen
8760,	cate be executed physicien and the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cons d.	equance of).	C	Col	m_	Car	ic ei				
O. Box 6	The law requires that the death certificate ate has been signed by the attending physoage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of prec 1 Live birth 2 Fi 4 Pregnant at time o	etal death 3	⊒Ectopic ⊒ Other (ś	oregnancy specify)				2	3d. Date of d Month	,	'ear
rds, P.	w requires that been signed t should be det	þ	Part II. Other significant conditions of	ontributing to death but not i	resulting in the u	underlying	cause given	in Part I.		23e. Did to		1	to the cause of d	
al Records,		Completed										24b. Were prior to death'		available ause of
Vital	certifical	Be	25. Was case referred to medical examiner?	Hospital:			Other			heck only o				
of	Attending Physician: r death. sctor: After this certific by the funeral director.	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year,	28b. Time of Injury		28c. Injury a Work?	4 1401	280	5 🗌 Resid		Other (Sp	necify)	
Division	of or Attendi after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Abuilding, etc. (Spe		reet, facto	ry, office		281	Location (S City or Tox	Street and wn, State)	Number or	Rural Route Numi	ber,
	To the Hospitel or Att within 24 hours after d To the Funeral Direct completely filled in by	Medical C	29a. Certifier Check only one) Certifying Physics 2 Medical Example 1	ysician: To the best of my kniner: On the basis of examand manner stated.	knowledge, dea ination and/or in	th occurre nvestigation	d at the time n, in my opir	, date and nion, deat	d place, and h occurred	due to the at the time,	cause(s) date and	and manner place, and d	as stated. ue to the cause(s)	
	To the within 2 To the complet	×	29b. Signature and title of certifier			2	c. License	number			29d. Date	signed (Mo	nth, Day, Year)	
	. 1		1/3/1	un			16	65	0		00	+ 2	nth, Day, Year) 1, 200 22 S Gre	5
E	HVIF		30. Name and address of person who o	completed cause of death (I	tem 23a) (Type	, Print)	-	11.	. 1.	٠ ٨٨ -	1	1 -	22 6 1.	
-	Sta	te.	31. Date filed (Month, Day, Year)	OR Foottrays SP	MINE Z	ity	Ot	11/60	y Ker	11/00	0	ver, 2	C > Ore	enst
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	•	For State of M State of M Registrar	-	Department of Health and M Certificate of Death		2005	35886
Dhusisi		1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	n Day Year	3. Time of Death
Physicia /Medic	al	Thomas Frederick Murphy			OUTUBER	1	
Examin	er	Solvan Hos PITAL OF BALTIMONE)	4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Deat	n
Funeral		5. Social Security Number 6. Sex 7. A	ge (In yrs. last bir	thday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,	9. Birt	hplace (State or Foreign
Director		213-32-2130	70	Yrs. Months Days Hours Min.	Jul 12,	1935 Mai	cyland
and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	n or Location			10d. Inside City Limits
Maryl	tor	Maryland Carroll		Hampstead			1 ☐ Yes 2 ☑ No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene and Mental Hygiene are as a second to the file and any injury or other traumatic event, the Medical Examinar must be nutilized and once.	Director	10e. Street and Number 3797 Dakota Road		10f. Zip Code 21074	10	og. Citizen of What Co USA	untry?
death ms 23	Funeral	11 Marital Status 12. Was Decedent	Ever in U.S.	13. Was Decedent of Hispanic Origin? (Spr If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race · Ame	
or Ites		Armed Forces 1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ If Yes, Give		1 ☐ Yes 2 ☑ No Specify:	Rican, etc.)	Black, White	e, etc. white
ural',	d by	3 Widowed 4 Divorced Year or Dates:	1964				
in 72 "nat	ojete	15. Decedent's Education (Specify only highest grade completed)		Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing	6b. Kind of Business/	
d with giene. rr thai	Completed	Elementary/Secondary (0-12) College (1-4or	5+)	Clerk		Oil Compa	any
al Hy d other	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Name			
ould Men marke	2	Lawrence J. Murphy	404		a Stromb		Zin Codol
d 2 st th and 17 is n traun		19a. Informant's Name/Relationship (Type, Print) Barbara Murphy, wife		o. Mailing Address <i>(Street and Number or Rura</i> 3797 Dakota Road, Ham			ip Code)
s 1 an f Heal item 2 other		20a. Method of Disposition	20b. Place o			20c. Location · City or	Town, State
Page: nent o int: If		1 Burial 2 □ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify)	9		2/2005	Mancheste	er, MD
permit. Departm Imports any inju		21. Signature Funeral Service Licensee Miles	723	22. Name and Address of Facility		uneral Hor	
1 205 20		* Auer We de	un	934 South Main St			L074 Approximate
		23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each Immediate Cause (Final	line.	1	or respiratory arre	SI,	Interval Between Onset and Death
Pnysician /Medical		disease or condition a. ACU	S a consequence	ARDIAL INFARCTICAL			201443
Examiner			- u - o i i o quo i i o o				
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ath cer tendir	Physician/M		2 Fetal death			23d. Date of del Month	ivery Day Year
the at	ysici	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant : 9 ☐ Unknown 9 ☐ Unknown	at time of death	5 Other (specify)		Work	Ju) . Ju
res that the designed by the		Part II. Other significant conditions contributing to death	but not resulting i	n the underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
quires nn sigr uld be	ed by	HYDERTEWIND			1 □ Ye	s 2□No 3□Pr	obably 4 Unknown
e law requir has been si je 2 should	Completed		<u></u>		24a. Was an autopsy	prior to	topsy findings available completion of cause of
	Com				perform	ned2 death?	2 No
ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner? Hospital:		26. Place of Deat			
Attending Physician: r death. sctor: After this certifici by the funeral director.	1; To	1 ☐ Yes 2 ☐ No ☐ 105 Planting 27. Manner of Death		Time of 28c. Injury at	me 5 Resider 28d. Describe ho		cify)
nding Ph ath. r: After thi e funeral	atior	1 → Natural 5 □ Pending (Month, D 2 □ Accident investigation	ay Year)	Injury Work? M 1 Tyes 2 No			
or Attendi after death. Director: A in by the fu	ertification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of It building, 6	njury - At home, fa	arm, street, factory, office	28f. Location (Str City or Town,	eet and Number or Ru , State)	ural Route Number,
spital or Atten ours after deat eral Director: fitted in by the	O						
To the Hospital or Attention within 24 hours after death to the Funeral Director: completely filled in by the	Medical		of examination ar	e, death occurred at the time, date and place, nd/or investigation, in my opinion, death occurr			
withir To the comp	Me	29b. Signature and title of certifier		29c. License number	29	d. Date signed (Mont	h, Day, Year)
		- South Ci M.	Ø .	RE3-000		TOBA / 18 05	
× + ×	,	30. Name and address of person who completed cause of	death (Item 23a)	(Type, Print) PITAL UF BALTIMUR F	2401 W.	BELVEDERE	AVE.
Sta	ite	31. Date tiled (Month, Dav. Year) 1 32. Regin	rar's Signature		DALTIM	TORE, TIARY	LIND WIGHT
Regist		OCT 2 0 2005	new l	* Sparle			

		•	State of Maryland / Dep State Registrar State of Maryland / Dep	artment of Health and Natificate of Death	Mental Hygie	711115	35887						
4.	1 . TA.	% P	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Davis Varia	3. Time of Death						
	Physicia /Medic		Irving R. McGhee		October	Day Year 18. 2005	10:13 ^a M						
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deatl							
			Holy Cross Hospital	Silver Spring		Montgom	erv						
3	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	ar) 9. Birtl	hplace (State or Foreign untry)						
	Director		432-28-0241 86		Nov. 3, 1	918 Penn	sylvania						
7	3		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits						
	show	ō	Maryland Montgomery Silver S	'mad ma			1 ☐ Yes 2 ☑ No						
4	a or 28a-f show	Director	Maryland Montgomery Silver S	10f. Zip Code	10g.	Citizen of What Co	untry?						
	Sa or		10409 Inwood Avenue	20902		USA	,						
4000	il', or items 23a c	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Ame							
,	1		1 Never Married 2 TxMarried 1x Yes 2 No		o Rican, etc.)	Black, White							
3	, a .	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1942-45	1 ☐ Yes 2 № No Specify:		Specify:Whi	te						
	le de la constant	Completed		dent's Usual Occupation kind of work done during most of work		o. Kind of Business/l	Industry						
1	giene. r than "natu	npi	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)									
1	ygier t	S		rtographer		Federal G	overnment						
	d off	Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, Mai	<i>den Suma</i> me)							
7	Men	은	Irving R. McGhee	Alma S									
	le no			ng Address (Street and Number or Ru									
· .	Health		Kathleen McGhee/ Daughter 1040 20a. Method of Disposition 20b. Place of Disp	9 Inwood Avenue,		ring, Mary							
5	perimit. Tages i and Aeria England being within popular. Tages i and Aeria Hygiene important: if item 27 is marked other than "any injury or other traumatic event, the Macangare.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	matory or other place) Octo	ber 25	. Location - City of	TOWN, State						
	Tan I						ing,Maryland						
ק ו	mpo mpo mny ir		FT	2 Name and Address of Earlity ancis J. Collins O University Blvd	Funeral Ho	ome Inc	MD 00003						
							, MD 20901 Approximate						
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,		Interval Between Onset and Death						
	hysician		Immediate Cause (Final disease or condition a. Acute Myocardial resulting in death)	Infarction									
	/Medical xaminer		Due to (or as a consequence of):	77 . D.									
	· -	10	Sequentially list conditions, if any, leading to immediate Arteriosclerotic Heart Disease Due to (or as a consequence of):										
7	nsit	Examiner	trany, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury Cause (Disea										
	sicien and burial-transit	xai	that initiated events resulting in death) Last c. Due to (or as a consequence of):										
3	hysicien and the burial-transit	dicai E	C _a										
		edic	V										
<	attending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deli	very						
1	d for	lcia	in the past 12 months? 1 Ves 2 No. 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		Month	Day Year						
)	ed by the detached	hys	9 Unknown										
necolus, r.o. Dox o	igned be det	by P	Part II. Other significant conditions contributing to death but not resulting in the	inderlying cause given in Part I.	23e. Did tobao	co use contribute to	the cause of death?						
3	been sig				1 ☐ Yes	2 ½ No 3 □ Pro	obably 4 Unknown						
3	s bee	Completed			24a Wasan	24b. Were au	topsy findings available completion of cause of						
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9	tifica tor, p	8	25. Was case referred to medical	26. Place of Dea	th (Check only one)	140 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1							
	is cer direc	To B	examiner? 1 ☑ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2√☐ ER/Outpatie	Othor	ome 5 Residence	e 6 □Other (Spec	cify)						
5	er th neral		27. Manner of Death 1. Manual 1. Manual 28a. Date of Injury (Month, Day Year) Injury 1. Manual 1. Manual 28b. Time of Month, Day Year)		28d. Describe how i								
5	ath. ne fur	atio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No									
<u> </u>	er de recto	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S		ral Route Number,						
5	rs aft ref Di ref Di	Cer											
	To the Topping the death. To the Funeral Director; After this certification of the Funeral Director; After this certification of the Funeral director, the funeral director director, the funeral director dire	edical	29a. Certifier (Check only (Check only Medical Examiner: On the basis of examination and/or in										
	the I	Med	one) and manner stated.										
i	To Co		29b. Signature and title of certifier	29c. License number D12121		Date signed (Mont							
1	21		seone in sengular	0		ctober 20	, 2005						
•			30. Name and address of person/who completed course of death (Item 23a) (Type										
	10 2			a Drive, Wheaton,	MD 20902								
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 4 2005 32. Registrar's Signature	and a series									
	100		E. M. W. W. W. W. W. W. W. W. W. W. W. W. W.										

Replacement Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiens (11/04/05dhb) L1/04/05dhb Reg. No. 1 - For State Registrar 35889 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Carole Marlene McGinthy 5:02 P August 14. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington County Hospital Hagerstown Washington Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 KF 65 Director 1940 557<u>-54-6312</u> Washington, DC Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in then "natural", or Items 23a or 28a-f show the Medical Expedient rest be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Washington County Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1967 Londontowne Drive 21740 S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian be filed within 72 hours after de ntal Hygiene od other then "natural", or Items Black, White, etc. 1 Never Married 2X Marned Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Church 12 Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be Is marked Arthur Compton Mary Blagg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m any injury or other traum <u>once.</u> Archie R. McGinthy/Husband 1967 Londontowne Drive, Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory Aug. 18, 2005 Smithsburg, Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee Daniel O. Pauley Jr. per DVR 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pneumonia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed anding physicien and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant ed by the attended for us 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 X No 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Status-post surgery for small bowel obstruction, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Hypertensive arteriosclerotic cardiovascular disease, Chronic obstructive pulmonary disease this certificate 1 Yes 2CXNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1X Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) : After thi 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation ours after death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ö within 24 hours a To the Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier O.C.M.E. November 2, 2005

State Registrar

4 2005 DHMH 17 Rev 1/2001

Jim.

31. Date filed (Month, Day, Year)

11/40 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

m.1)

111 Penn Street, Baltimore, Maryland 21201

				For State Registrar	State of	Marylan		artment of hartificate of	Health and I <i>Death</i>		lieme ()	05	35890
	3		5	1. Decedent's Name (First, Middle, Last	1)					2. Date of Dea		Vone	3. Time of Death
\\ \ _		Physici /Medic		Norma J. Miedzins	ki					Octobe:	r 18.	2005	4:38P. M
12		Examin		4a. Facility Name (If not institution, give		_			or Location of Deatl	h		nty of Death	
2	(C ₃₂)		u jā	Doctors Community				Lanhan		(5)			George's
N		Funeral		5. Social Security Number 6. Se 214–30–1047	X ☐ M 2√2 F	7. Age (In yrs.	71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Feb. 27	Year)	Cour	
Miedzi	Test.	Director		Usual Residence of Decedent	Λ		/			rep.27	, 1934	Nebr	aska
1,0		anyland ehow		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation				1	0d. Inside City Limits
6		the Maryla 28a-f ehor	to	Maryland Prince G	eorge's	Ne	w Carro	ollton					¹X Yes 2 □ No
		or 28a-f	irec	10e. Street and Number				10f. Zip Code		1	l0g. Citizen o	of What Cour	ntry?
رما		urs after death with at, or items 23a or Examiner must be	Funeral Director	6016 Mentana Stree	t			207	784		Unit	ed Sta	ites
+		items	Iner	11. Marital Status	12. Was Dece Armed For	dent Ever in U	.S. 13. V	Was Decedent of I f Yes, specify Cub	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No- to Rican, etc.)		lace - Americ	
9	36	or li	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes If Yes, Giv	е		I□Yes 2[X]No	Specify:		Spe	city: Wh	nite
5	5-0036	within 72 hours after death with the Maryland ene. than "naturat", or items 23s or 28s-f ehow the Madical Examiner must be notified at	ed b	15. Decedent's Edi	Year or Da	1105:	16a Deced	ient's Usual Occu	nation		16h Kind of	Business/Inc	dustry
6,	215	in 72 n" r	ojet	(Specify only highest grad	de completed)		(Give	kind of work done DO NOT use retire	during most of wor	rking	100. 11110 01	Duomosam	Sustry
7	212		Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)	Bookl	keeper			Sale	s	
	D	be filed ntal Hygie od other event,	BeC	17. Father's Name (First, Middle, Last)					18. Mother's Nan	ne (First, Middle,	Maiden Sum	ame)	
4	Marylan	D 9 7 0	To E	(unk)		Greenf	ield		Florenc	e	Knick	erbock	er
JRMA	an	d 2 shou th and M 7 is mar traumat		19a. Informant's Name/Relationship (T				-	t and Number or Ru				
5		Health tem 27		Michael Miedzinsk	i -son		_		Ash Cour				
3	Baltimore,	permit. Pages 1 and Depertment of Health Important: if item 27 eny injury or giver 1 once.		20a. Method of Disposition 1 Burial 2 XCremation 3	Removal from S	State	cemetery, cren	sition (Name of natory or other pla				n - City or To	
	Ë	tant:		4 □ Donation 5 □ Other (Specify)	Me ⁻				/20/2005	Alexa	ndria,	Virginia
	Sai	permit. Depertrimports imports eny inju		21. Signature of Furer Service L cens	500			Name and Addre	ess of Facility Borgward	t Funera	l Home	. PA	
		40204		My 11111	recell	Res	/ 1/	INA Powde	r Mill P	oad Palte	2571]]		20705 Approximate
_				23a. Part1. 5 from the disease, or composhock, or heart failure. List only of	ne cause on ea	ach line.	n. Do not enti	er the mode of dyl	ng, such as cardiad	or respiratory arr	est,		Interval Between Onset and Death
		Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	atory o		se					
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	Ö	s afte	Certification:		Dulidir	ig, etc. (Specii	(y)			City or Tow	n, State)		
		To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 157 Certifying Phy (Check only 2 Medical Exam	sician: To the	best of my kno	wiedge, death	occurred at the tr	me, date and place	and due to the c	ause(s) and	manner as st	ated.
		the h vin 24 the F uplete	fedical	one)	and mann	ner stated.	on and/or in						
		To To	Σ	29b. Signature and title of certifier		1 2 1		29c. Licen.			9d. Date sig.	ned (Month,	Day, Year)
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				30. Name and address of person who p	ompleted cause		\wedge	Print)	loy Bo	./. A	21 2	2202	
	199		5	31. Date filed (Month, Day, Year)	32	207 (VUISIA	Jerry 4	104, 30	1 11	10c d	UIXU	
	(100) (20) (40)	Sta Registr		OCT 2.1.20	105	Mar 0 1	& An	PALL	•				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 19, 2005 4c. County of Death /Medical Naomi Laughlin Meyers October | 5:30a 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death Examiner 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hi 13716 New Hampshire Avenue Montgomery Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2 Days Hours 266 28 5303 92 Yrs. Director March 11, 1913 Illinois Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or Items 23a or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Montgomery Silver Spring 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? with death Funeral 13716 New Hampshire Avenue 20904 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes ZENo Specify: þ Specify ₩idowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7; th and Mental Hygiene." 7 Is marked other than "na College (1-4or 5+) Elementary/Secondary (0-12) President Real Estate Company permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygies
Important: if Item 27 is marked other to
any Injury or other traumatic event, Inonce. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jesse Meyers Mary Macke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health ar John F. Weddell / Attorney 11109 Hoffman Drive Germantown, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemeteyr 10/24/05 Silver Spring, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines Rinaldi Funeral Home 21. Signature of Funeral Se vic ∫ Li nsee 11800 New Hampshire Ave Silver Spring, MD 20904 23a/ Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Essential Hypertension disease or condition resulting in death) Years /Medical Due to (or as a consequence of) **Examiner** <u>Cardiovascular Disease</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Years Examiner Due to (or as a consequence of) certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician ian/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ▼ No Year 4☐Pregnant at time of death Month Day Physici 5 Other (specify) P.O. be detached Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 1 Yes XXNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Division of Vital 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2x No 25. Was case referred to medical 26. Place of Death Check on one examiner Hospital: 1 | Inpatient Other: 4 Nursing Home Residence 6 Other (Specify) 1 Tyes 2X No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Hospital or Attending Injury 1X Natural 5 Pending after death.

Pirector: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Direct 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) ∧ 29b. Sign tule and title of certifier 0 29c. License number 29d. Date signed (Month, Dav. Year) 20 omuse D03835 October 19, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Cromwell, M.D. 831 University Boulevard East Silver Spring, Maryland 20903 31. Date filed (Month, Day, Year) 32 Registrar's Signature OCT 21 2005 Registrar

			For Stata Registrar	State of Ma	ıryland / Dep <i>Ce</i>	artment rtificate	of Health ai <i>of Death</i>	nd Mental H	ygien Reg. N	000	35892
4-	Discourse		1. Decedent's Name (First, Middle, La	st)				2. Date of E		ay Year	3. Time of Death
	Physici /Medic		Mary Frances Me	rkl				0ctob	er 20	0, 2005	2:35 A M
67	Examir		4a. Facility Name (If not institution, given			4b. City, To	wn, or Location of	Death	40	c. County of Death	
٧.			Southern Marylar				linton			Prince	George's
	- Funeral Director		5. Social Security Number 6. S 265-14-2799	7. Age	(In yrs. last birthday,	Months I	Year If Under 24 Days Hours	Min. (Month, L	Dav. Year	9. Birth Cou 1918 Geor	place (State or Foreign
	pu &		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	coation					
	h the Maryland r 28a-f show Lnotified at	'n									10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	he N	Director	Maryland Prince	George's	Uppe	r Marl			1		
	with a or	ក់		0		10f. Zip C	2077	72	10g. C	itizen of What Cou	ntry?
	death w	erai	11905 N. Marlton	AVENUE 12. Was Decedent B	ever in II S 12	Mac Dooder					an Indian
Maryland 21215-0036	or Ite	by Funerai	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2XN If Yes, Give Year or Dates:		If Yes, specify		n? (Specify Yes or N Puerto Rican, etc.)	10-	14. Race - Ameri Black, White, Specify: Wh	
9	72 hours natural', ilicul Exz	Completed	15. Decedent's E (Specify only highest gra	ducation	16a. Dece	dent's Usual (Occupation	- formation	16b.	Kind of Business/In	dustry
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lar	2 sh and le m		19a. Informant's Name/Relationship (*				or Rural Route Num			
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Baltimore,	Pages 1 nent of H ant: If ite ury or ot		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Disponentery, cre	matory or othe	r place)	Date		ocation - City or To	own, State
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Bal	permit. Pages Department of Important: If i any Injury or once.		21. Signature of Funeral Service Lice	MO(,000		Address of Facility			x 156	
/			23a. Part1. Enter the disease, or com	of Cervi			uneral Ho			MD 2060	
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68760,	ficate be executed g physician and as the burial-transit	edicai Exa	that initiated events resulting in death) Last	Due to (or as a	consequence of):						
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O. Box	res that the death certifi signed by the attending be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 🔼 No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at the 10 ☐ Unknown	2 Fetal death 3	□Ectopic preg □ Other (spec				23d. Date of delive Month	ery Day Year
P.0	that the ded by detail	F.	Part II. Other significant conditions	ontributing to death bu	t not resulting in the u	inderlying cau	se given in Part I.	23e. Did	tobacco	use contribute to the	ne cause of death?
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Division of Vital Records,	Attendi er death. ector: A by the fu	iii	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	286. Place of inju	ry - At home, farm, st	reet, factory, o	ffice	28f. Location	(Street at	nd Number or Rura	I Route Number,
Ö	rs afte	Cert		building, etc.	. (Эрвину)			City or To	own, State	8/	
	To the Hoepital or Attanding Physician: To the Funeral Director: After this certific completely filled in by the funeral director,	edical Certification;	29a. Certifier 1 Certifying Pt (Check only one) 1 Medical Example 1	ysicien: To the best o niner: On the basis of and manner stat	examination and/or in	h occurred at vestigation, in	the time, date and my opinion, death	place, and due to the occurred at the time	cause(s , date an	s) and manner as s d place, and due to	tated. the cause(s)
	To th Withir To th	Me	29b. Signature and title of certifier			29c. L	icense number		29d. Da	ate signed (Month,	Day, Year)
			Margueses	aus		D.	48158		OCT	.20,20	205
(ŀ	30. Name and address of person who		ath (Item 23a) (Type,		60120		-	. 20,00	~ >
1	SB 20		5150m OSIA,6	192 0XON	HILL ROT		E 500,	OXON H	ILL .	MD 207	445
	Sta		31. Date filed (Month, Day, Year) OCT 2 1	2005 32. Revistra	r's Signature	Sant !	1				

State of Maryland / Department of Health and Mental Hygienen 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JOSEPH VASSAR WILLIAM 9:10PM 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death PRINCE RINCE GEORGES GEORGES HOSPITAL CHEVER If Under 1 Year II Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **№** М 2 🗆 F 030-16-5107 78 Director 1927 New Hampshire April 3, Usual Residence of Decedent death with the Maryland show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or Items 23e or 28a-f shov Exstriner coust be notified at Director Maryland Prince George's Cheverly 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2811 Park Way Funerai 20785 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Iter any injury or other traumatic event, the Medical Exactin Black, White, etc. 1 Never Married 2 Married 1 Tyes 2 No If Yes, Give Year or Dates: WWII Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 € No 3€ Widowed 4 Divorced Specify White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Systems Analyst Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Victor Nassar 2 Afdock Unavailable 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph W. Nassar, Jr./ Son 9229 St. Andrews Place, College Park, MD 20740 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veteran's Cemetery-20a. Method of Disposition October 25 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ¹ 4 ☐ Donation 5 ☐ Other (Specify) 2005 Cheltenham, Maryland Cheltenham 21. Signature Aneral Service Licensee Francis J. Collins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death SEPSIS Immediate Cause (Final Physician disease or condition resulting in death) 4 HOUR /Medical Due to (or as a consequence of): **Examiner** OBAR PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit ING Due to (or as a consequence of). Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea:
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Day Month Year 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, CHRONIC LYMPHOCYTIC 1 ☐ Yes 2 ☐ No 3 Probably Completed UNCONTROLL 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed? METABOLIC CIDOSIS 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 💥 No Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending s after death. death. investigation 1 Yes 2 No the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) INEZ GILBERT-MCC 31. Date liled (Month, Day, Year) 32. Registrar's Signature State Registrar 2 4 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiette O C

	_1	For Stete Registrar	Otate of Mid		Certificate	of Death	R	leg. No.	35894		
Physiciar /Medica			NEVWORT	4			2. Date of Dea Month	Day Yes	7. 7 /7.1		
Examine		la. Facility Name (If not institution, given Howard County		spital	4b. City, Tov	m, or Location of Death bia		4c. County of D	rd		
Funeral Director		5. Social Security Number 6. S 194.01.6660	Sex 7. Age	(In yrs. last birth	hday) If Under 1 Y Months D	ear If Under 24 Hrs. Ays Hours Min.	8. Date of Birth (Month, Day Februar	y 12,1916	Birthplace (State or Foreign Country) Pennsylvani		
Maryland -f ehow	1	10a. State 10b. County Howar	d	10c. City, Town Ful	or Location				10d. Inside City Limits 1 ☐ Yes 2 No		
th with the Mar		10e. Street and Number 12401 Lime K	iln Road		10f. Zip Co	0759	1	0g. Citizen of What	•		
should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other then "natural", or items 23s or 28s-f show imatic event, the Modical Exerting must be notified at	2	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Wildowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Tyes 2 ZAN If Yes, Give Year or Dates:		13. Was Decedent If Yes, specify 1 ☐ Yes 2 🛣	of Hispanic Origin? (Sp Cuban, Mexican, Puerto No Specify:	pecify Yes or No- Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, Thite, etc. White		
ed within 72 hor ygiene. ner then "naturi t, the Madical	nanaldille	15. Decedent's E (Specify only highest gr Elementary/Secondary (0·12)	ducation ade completed) College (1-4or 5-)	Decedent's Usual O (Give kind of work d life. DO NOT use n	ocupation one during most of won atired)	of working 16b. Kind of Business/Industry Education				
	ם ם	17. Father's Name (First, Middle, Last Henry Brown)				nme (First, Middle, Maiden Sumame) lline Brandt				
nd 2 shoulth and M		19a. Informant's Name/Relationship				reet and Number or Ruind Court (•	a, Zip Coda) 21209		
permit. Pages 1 and 2 should be Depertment of Health and Menta Importent: If Item 27 is marked any Injury popther traumatic averages.	2	or Town, State									
permit. Depertiment import any inj		21. Signature of Fund Servic Lice	Kon	/	5130 Wis	ddress of Facility Jos consin Aver	nue NW Wa	ashington	DC 20016		
Physician /Medical Examiner		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. PNEUM			dying, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death 3 DAYS		
ifficate be executed gphysicien and as the burial-transit	Examilia	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	consequence o							
The law requires thet the death certifica tie has been signed by the ettending phoage 2 should be detached for use as the considerable to the consideration of the considerable to the consideration of the consideration o		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of the line of the li	2 ☐ Fetal death	3 ☐ Ectopic pregn 5 ☐ Other (specifi			23d. Date of Month	delivery Day Year		
S 60 6	<u>`</u>	Part II. Other significant conditions	contributing to death bu	t not resulting in	the underlying caus	e given in Part I.			o to the cause of death? Probably 4 Unknown		
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or Attending Ph fter death. Director: After th n by the funeral		27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigatio 6 Could not to determined	00 Place of Inju	Year) In	ime of jury M 28c.	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe ho	ow injury occurred	Rural Route Number,		
he Hospital of 24 hours a he Funeral Dietely filled i	edical	29a. Certifier (Check only one) 1 Certifying for 2 Medical Exa	hydrian. To the basis of miner: On the basis of and manner sta	examination and	death occurred at II	ne time; data and place my opinion, death occu	and due to the or rred at the time, d	cuse(s) and manner late and place, and c	due to the cause(s)		
4		29b. Signature and title of certifier				cense number		9d. Date signed (Mo			
ω		30. Name an laddy ss of person who	Completed cause of de	path (Item 23a) (Type Print)	D5 1860	COWMA	OCT 19	1044		
State Registra		31. Date filed (Month, Day, Year)	32 Registra	r's Signature	Sperle	IVE # 210			•		

			1 - For State Registrar	State of M	Marylan		artmen <i>tificate</i>			nd Men		979 O	5	358	95
	Physic	ian	1. Decedent's Name (First, Middle, La	st)						1	Date of Death Month	Dav	Year	3. Time o	of Death
-0	/Medi	cal	MAURICE OGINZ								TOBER		005	8:40) A ^M
	Exami	ner	4a. Facility Name (If not institution, giv SHADY GROVE ADVEN'				4b. City,		ocation of the CKVILL	LE		4c. County		TGOMERY	Z
¥	Funeral Director		020-03-1304	ex 7 □XM 2□F	Age (In yrs. i	ast birthday) Yrs.	If Under Months	1 Year Days	Hours 24	Min. 8. C	Date of Birth Month, Day, RCH 6,	^{Уваг)} 1913	9. Birth Con MA	nplace (State untry) ASS.	or Foreign
tu t	Maryland -f show	_	Usual Residence of Decedent 10a. State 10b. County MARYLAND MONTGOI	MERV	10c. City	, Town or Lo	cation		CUUTI	T 17				10d. Inside C	
8:40 Am	n the Marine 1888-f	Funeral Director	10e. Street and Number	TEKI			10f. Zip		CKVIL		10	g. Citizen of \	What Co		2 □ No
	23a or	aD	6111 MONTROSE ROAD	D						20852			U.	S.A.	
36 at	hours after death with the Marylar ural; or items 23a or 28a-f show I Examinat hars be notified at	by Funer	11. Marital Status 1 □ Never Married 2 □ Married 3 ◯ Widowed 4 □ Divorced	12. Was Decedel Armed Force 1 Tyes 2X If Yes, Give Year or Dates	s?] No	11	Vas Deced Yes, spec	ify Cuban,	anic Origin Mexican, F Specify:	n? (Specify Puerto Ricar	Yes or No- n, etc.)		ck, White	ncan Indian, o, etc. WHITE	
15-0036	72 hours "natural"		15. Decedent's Ed (Specify only highest gra	l ducation		16a. Deced	lent's Usua kind of wor	l Occupati k done dui	on ring most o	of working	1	6b. Kind of B	usiness/l	ndustry	
2121	should be filed within and Mental Hygiene. s marked other than "umatic event, Ine Max	Completed	Elementary/Secondary (0-12)	College (1-4o 2	or 5+)		OO NOT US ACCOUI					ACCOU	NTIN	IG	
Maryland	old be fil Aental H rked oth	To Be	17. Father's Name (First, Middle, Last) ISAAC OGINZ					1		s Name <i>(Fir</i> s RTHA F		aiden Suman	ne)		
an	2 sho and h Is ma		19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address	(Street and	d Number o	or Rural Rou	ute Number,	City or Town,	State, Z	ip Code)	
Baltimore, M	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical ance.		HAROLD M. OGINZ/SC 20a. Method of Disposition 1 XBurial 2 Cremation 3 C	Removal from Stat	te C6	ace of Dispos metery, crem	sition (Nam atory or ot	e of her place)		Date	26	TH BET	City or T	own, State	20852
Ē	permit. Pag Department Important: I any injury o		4 □Donation 5 □Other (Specify 21. Signature of Funeral Service Licen		hope	EAN MEM)/20/0		NEY, M		AND	
B (Departr Departr Imports any inj		1 Character			EI	WARD	SAGE	L FUN	IERAL :	DIRECT	ION,IN	C.	ANTE OO	0.50
	Physician /Medical		23a. Part L'Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	olications that caus		. Do not ente	or the mode	of dying,	such as ca	ardiac or resp	piratory arres	it,	ARYL	Approximat Interval Bet Onset and	te ween
68760,	icate be executed physicien and physicien and sthe burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or a	as a consequ	ence of):									
P.O. Box 68	The law requires that the death certific. Ite has been signed by the attending pl age 2 should be detached for use as i	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 🗌 Fetal	death 3 □i	Ectopic pre Other (spe					23d. Dat			Year
	uires that n signed b	by	Part II. Other significant conditions of Acute Rend	ontributing to death	but not resu	lting in the un	derlying ca	use given	in Part I.	2		cco use conti	ibute to t	\ /	death? Jnknown
of Vital Records,	ne law requir s has been si ge 2 should	Completed	Clostridiun	n Difficile	Coli	his				2	24a. Was an autopsy performe	, F	Vere autorior to colleath?	opsy findings ompletion of c	available ause of
ā			25. Was case referred to medical								☐ Yes 2		Yes	2□ No	
>	Physician: this certificatal director, I	To Be	examiner?	Hospital: 1 Inpai	troot 3 🗆 E	R/Outpatient	3 DO	Othor			ck only one)				
on of	ing After une		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of In (Month, D	jury	28b. Time of Injury		c. Injury at Work?		28d. D		ce 6 □Othe injury occurr		fy)	
Division	Ne Hospital or Attending 124 hours after death. Ne Funeral Director: Attentioletely filled in by the fune.	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	288. Place of I	njury - At hor atc. (Specify)	me, farm, stre			2 2 140	28f. Le	ocation (Stre lity or Town,	et and Numbe State)	er or Run	al Route Num	ber,
	To the Hospital or within 24 hours at To the Funeral D completely filled in	Medical	29a. Certifier 1 Certifying Phyone) 1 Medical Exam	vsician: To the besiner: On the basis and manners	or examinati	vledge, death on and/or inve	occurred a estigation, i	t the time, in my opini	date and p	place, and di occurred at	ue to the cau the time, date	se(s) and ma and place, a	nner as s ind due t	tated. o the cause(s)
	To th withir To th comp	Me	29b Signature and title of pertifier	1			29c.	License n	umber		290	I. Date signed	(Month,	Day, Year)	
	3		30. Name and address of person who d		D.	23a) (Tuno B	(rint)	D626	53		00	TOBER	19,	2005	
			0		M.D.			E ADV	ENTIS	ST HOS	PITAL.	ROCKV	TI.I.E	E. MD 2	0850
7 (00) (4)	Sta Registr		31. Date filed (Month, Day, Year)	450	trar's Signati		entre)				,			2 سن د	-0000

			For State Registrar	5	State of	Marylar	•	artmer <i>rtificat</i>			and M	ental Hy	giene Reg. No.	005	3	35896	
15	£.		Decedent's Name (First, Middle	e, Last)								2. Date of De.	ath Day	Ye	25	3. Time of Death	
т	Physicia /Medic		William Joseph	0'He	rn							Octobe		, 200		8:16pm M	
	Examin		4a. Facility Name (If not institution			iber)		4b. City,	Town, or	Location of	of Death		4c.	County of E	Death		
			Shady Grove Adv	venti	st Ho	spital			ville				Мо	ntgom	ery		
	Funeral		5. Social Security Number	6. Sex		7. Age (In yrs.		If Unde Months	r 1 Year Days	If Under:	Min.	8. Date of Birt (Month, Da	y, Year)		Count		
	Director		128-09-0254	1631	201	88	Yrs.					Feb. 1	, 19	L7 Ne	ew Y	ork	
	and w		Usual Residence of Decedent 10a. State 10b. County			10c. Ci	ity, Town or L	ocation							10	d. Inside City Limits	_
	Aaryli e ho	ŏ		0m 0 7	.,	Cod	thorch	ura								1 X Yes 2 No	
	the A	Director	Maryland Montg	omer	у	Gal	thersb		p Code				10a. Citi	zen of Wha	t Count	rv?	_
	with	۵	301 Russell Av	07110					2087	7			IIn	ited	Sta	ates	
	death with the Maryland ime 23a or 28a-f ehow	Funeral	11. Marital Status			dent Ever in U	J.S. 13.	1			gin? (Spe	ocify Yes or No Rican, etc.)		14. Race - /	America	an Indian,	_
	riten	F	1 ☐ Never Married 2 ☐ Mar	ried	Armed For	2 □ No 1	949-				n, Puerto	Rican, etc.)		Black, V	White, e	itc.	
ဗ္ဗ	urs a	þ	3 ଔWidowed 4 ☐ Divorced		If Yes, Give Year or Da	e ites: 1	953	1 🗌 Yes	2 X , No	Specify:				Specify:	Whi	te	
9	72 ho	Completed	15. Deceder (Specify only highe					dent's Usu		ation during mos	t of worki	na	16b. Ki	nd of Busin	ess/Ind	ustry	
21	thin 6.	n p	Elementary/Secondary (0-12)	J. grado d	College (1	-4or 5+)	life.	DO NOT	ise retired)		3					
7	ygien ygien yer th	Co			4		Manua	al Sc	ript	Writ					t o	f Navy	_
<u>n</u>	tal H	Be	17. Father's Name (First, Middle,	Last)								(First, Middle,					
Z	ould Men varke	ဥ	William O'Hern		0:		405 14-11		. (0			nces Cl			40 Zi-	Codel	_
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-f show entry injury or other traumatic event, the Madical Examiner must be notified at once.		19a. Informant's Name/Relations					•				I Route Numbe	•	r Iown, Sta	tθ, ∠ <i>ip</i> (Code)	
o,	l and lealth		William O'Lear	y (1	lephew		P.O. Place of Disp			walw		NY 14		cation - City	v or Toy	wn. State	
O	S = E		1 ☐ Burial 2 ☑ Cremation		noval from S	State	cemetery, cre	matory or	other plac	·							
Ë	t. Pa tmen tent:		4 Donation 5 Other (5			Me	tropol:	itan	Crema	atory	10/	23/05 Vol Fun	Alex	andri	a, '	Virginia	4
3a1	Deparement of the popular of the pop		21. Signature of Funeral Service	Licensee	11		110) Eas	t Dee	er Pa	rk D:	rive	егат	поше			
	40200		23a, Pag1, Epter the disease, o	(MA)	07	auend the dea				rg, M			rraet			Approximate	
н			shock, or heart failure. List	only one	cause on e	ach line.	DO 1101 01	101 1110 1110	do or ayırı	9,5001105	our dido c	0	1			Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition resulting in death)	_ a.		2001	ic m	400	ar	012	Lic	Asuc	7101	7		ninutes	_
	/Medical Examiner		, , , , , , , , , , , , , , , , , , , ,	1	Due to (or as a conse	quence of):	J			•						
8		L.	Sequentially list conditions, if any, leading to immediate	ь	Due to (or as a conse	quence of):										_
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	< −			,,-										
	be executed sicien and burial-transit	xar	that initiated events resulting in death) Last	C.	Due to (or as a conse	quence of):	_									
8760,	ate be executed hysicien and the burial-transit																
687	ficate physis the	Physician/Medical		u.													
Box (death certific e attending p id for use as f	Z/M	IF FEMALE: 23b. Was decedent pregnant	230		come of pregr								23d. Date of	f delive	ry	
ă	death atte	clai	in the past 12 months?		4 ☐ Pregn	inth 2 ∐ Fet ant at time of		⊒Ectopic ; □ Other (s						Month		Day Year	
0	the y th iche	hysl	9 Unknown		9□ Unkno	own											
٦.	pe ab	by P	Part II. Other significant conditi	ions conti	ributing to de	ath but not re	sulting in the	underlying	cause giv	en in Part I	Ł.	23e. Did t	obacco u	ise contribu	te to th	e cause of death?	
rds	n sign											1 🗆	Yes 2	□No 3[Proba	ably 4 DUnknown	
of Vital Records,	s been si should	Completed										24a. Was		24b. Wer	e autop	sy findings available	
Re	The la	E										auto perfo	ormed?	dear	th?	npletion of cause of	
tal		0	25. Was case reterred to medical	al T			,			26. Place	e of Death	(Check only			103	20 110	-
>	Physician: this certific ral director.	0 B	examiner? 1 ☐ Yes 2 ☑ No	Ho	spital:	npatient 2	ER/Outpatie	ent 3 🗆 D	OA Oth	er: 4 Nu	ursing Ho	me 5 Resi	dence	6 Other (Specify	')	
		n: T	27. Manner of Death		28a. Date	of Injury h, Day Year)	28b. Time	of	28c. Injun Wor	y at		28d. Describe	how injur	y occurred			_
Division	Attending in death.	atlo	1 ☑Natural 5 ☐ Pendi 2 ☐ Accident invest	ng tigation	(INC)	,,, bay . oa,,	injury	М		Yes 2	No						
Vis	or Attenualter deat Director: in by the	5	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	not be	28e. Place	of Injury - At	home, farm, s	treet, facto	ry, office			28f. Location (City or To			or Rural	Route Number,	
Ö	pital or At ours after o terel Direc filled in by	Certification:					,,					ŕ					
	To the Hospital within 24 hours of To the Funeral completely filled	_										and due to the					
	To the Hos within 24 hd To the Fun completely	ledical	one)			ner stated.											_
	with To	Σ	29b. Signature and title of certifi	er		1	t.	25	9c. Licens	e number	40	>	-	te signed (A			p-
	15		1 / /	M	10:	ms	~		U	• 20	1.15)				2,2005	>
	-		30. Name and address of person	who son	¥	se of death (Ite	9	11 (Suss	cll	Ave	. 6	aith	ersbu	G	Md	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year	200	.07	egistrar's Sign	nature	uli									

			1 - For State Amend Item Registrar	State of Mar 1 per Dr.,(yland / Dep 3849, Mon t	artment of F	lealth and 10/24/0 5	Mental Hyg	ene g. No.	5 35897
	Physic /Medi		Decedent's Name (First, Middle, Las Mary Margaret C Mary Margaret	Donohue a	aka Mary	Margaret (O ' Donogh	2. Date of Death Ue Month October	Day	3. Time of Death 12:10 P ^M
	Exami	ner	4a. Facility Name (If not institution, give				Location of Deat	h	4c. County of	f Death
1	Comment		Manor Care- Chev 5. Social Security Number 6. S.		n yrs. last birthday	Chevy C	nase If Under 24 Hrs	O Data of Birth		tgomery
	Funeral Director			□м 210 г	97 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Aug. 12,	rear)	9. Birthplace (State or Foreign Country) Michigan
	/land		10a. State 10b. County	11	Oc. City, Town or L	ocation				10d. Inside City Limits
	Man a-f eh	to	Maryland Monto	omerv	Chevy	Chase				1 ☐ Yes 2 X ☐ No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of WI	nat Country?
	ath w		4008 Thornapple			20815			U	SA
980	d within 72 hours after death with the Maryland Jiene. I then "naturel", or iteme 23a or 28a-1 ehow II'n Medical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates:	or in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	spanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)	Black	- American Indian, White, etc. White
Maryland 21215-0036	within ane. then	Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12) 12	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation furing most of wor)	rking	6b. Kind of Bus	ŕ
d 2	il Hygin other	BeC	17. Father's Name (First, Middle, Last)		560	cretary	18. Mother's Nar	ne (First, Middle, M	Educa	
/lan	Mental Mental rrked o	To B	John H. O'Donog	hue				ret Dalto		
lan	is 1 and 2 should be filed to the alth and Mental Hygelem 27 is marked other other traumetic event,		19a. Informant's Name/Relationship (7		19b. Maili	ng Address (Street a				tate, Zip Code)
	1 and 2 Health em 27		John P. O'Brien/		4008	B Thornapp	ole Stree		Chase,	MD 20815
altimore,	Pages nent of h		20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State		osition (Name of matory or other place of Cemeter	, , ,	ober 25		ity or Town, State
Balti	permit. Pages Department of I Important: If Ite eny Injuryor of		21. Signature Funeral Service Licens		3	Name and Addres	s of counting	s Funeral	Home T	, Michigan nc ring,MD 20901
Ar.	Physician		23a. Part1. Enter the disease, or compshock, or heart failure. List only Immediate Cause (Final	na cause on each line.	death. Do not en	ter the mode of dying	g, such as cardiac			Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a co	onsequence of):	ve Heart E				3 Months
18.		e.	Sequentially list conditions, if any, leading to immediate	Due to (or as a co		Heart Dis	ease	-		.9
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	,						
Ó.	ficate be executed physicien and s the burial-transit	Exa	resulting in death) Last	Due to (or as a co	onsequence of):					
68760,	cate b	edical		d						
P.O. Box 6	law requires that the death certifi as been signed by the attending. 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	Partie	35-	23d. Date of Month	,
ر. ص	s that	by Ph	Part II. Other significant conditions co	ntributing to death but no	ot resulting in the u	nderlying cause give	n in Part I.	23e. Did toba	cco use contribu	ute to the cause of death?
ğ	w require been sig should b							1 ☐ Yes	2√ □ No 3	☐ Probably 4 ☐Unknown
Ě	The ste h	Completed						24a. Was an autopsy performe	d? pric	re autopsy findings available r to completion of cause of th? Yes 2□ No
Vita	ician: Th certificete ector, pag	Be	25. Was case referred to medical examiner?	dansitali.				th (Check only one)		
	£ = =	2	1 ☐ Yes 2 ☒ No 27. Manner of Death	lospital: 1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatien		4 Xivursing inc	ome 5 Residence		(Specify)
o	ding F	tlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	ar) Injury	Work	es 2 No	28d. Describe how	injury occurred	
=	i i i i i	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, strepecify)			28f. Location (Stree City or Town, S	et and Number (State)	or Rural Route Number,
	To the Mospital within 24 hours a To the Funeral (completely filled	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of more: On the basis of war and manner wated.	y knowledge, death my ation and/or inv	n occurred at the time restigation, in my opi	e, date and place, nion, death occur	and due to the caus red at the time, date	e(s) and manner and place, and	er as stated. due to the cause(s)
	To To	2	29b. Signature and title of miffier	. //	100	29c. License	number	29d	Date signed (A	Month, Day, Year)
	10		30. Name and address of person who co	mple of and of death	(Item 23a) (Type, I	Print)	479		10/19	1/05
_			James Foster, M.	D. / 5/530 Wi	sconsin	Avenue, C	hevy Cha	se, MD 20	815	-
	Stat Registra	~	31. Date filed (Month, Day, Year) OCT 2 1 200	32 Registrar's S	Signature	ules				

State of Maryland / Department of Health and Mental Hygiene | For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** \mathbf{P}^{M} OCTOBER 19 2005 9:55 JAMES WILLIAM PFISTERER /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**∑**M 2□ F 207-16-7465 JAN. 10, 1929 Director PA 76 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Items 23a or 28a-f show ner myst be notified at 1 ☐ Yes 2 X No ANNE ARUNDEL ARNOLD Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 661 QUAIL RUN COURT 21012 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, other treumatic event, the Medical Examiner Black, White, etc. within 72 hours after 1 ☐ Never Married 2 📆 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ENTREPRENEUR INVENTING other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fit ment of Health and Mental H tent: If item 27 Is marked otf FRANK PFISTERER NELL GRACE 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GLORIA P. PFISTERER/WIFE 661 QUAIL RUN COURT, ARNOLD, MD 20b. Place of Disposition (Name of cometery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition CHESAPEAKE CREMATION CENTER, LLC. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of Importent: If eny Injury or one 10/20/2005 STEVENSVILLE, MD * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK RD., CHESTER, MD 21619 23a. Part1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congel + zue **Physician** Que to (ar as a consequence of) /Medical Examiner NEWMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine death certificate be executed use as the burial-tran resulting in death) Last Due to (or as a consequence of): physicien Physician/Medical attending | IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f o. 9 Unknown ۵ signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 22 No 1 Yes 1 patient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funerel Director: A 2 Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 - Homicide Hospitel 29a. Certifiei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 24 ho To the Fun completely 1 (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 2 D0046303 leted cause of death (Item 23a) (Type, Print)

M 2002 Medical Name and address of person Conticesy Such le Registrar

cian lical	Registrar 1. Decedent's Nar	ne (First, Middle,	Last)		Cel	uncau	e or L	Death		2. Date of D	Reg. No.	05	3 5 8 9 9
lical										Month	Day	Year	9:45 P M
iner	FANTA 4a. Facility Name	(If not institution, g		nber)		4b. City,	Town, or	Location of	of Death	Octobe		2005 ounty of Death	1 9:45 P
	Holy Cr	oss Hosp	ital					er Sp			Mor	itgomer	
1	5. Social Security		. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bi (Month, D	rth ay, Year)	9. Birth	place (State or Foreign ntry)
r	220-70-8 Usual Residence			81						May 28,	1924	Pol	Land
	10a. State	10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits
ctor	MD	Montgon	nery		Silver								1 ☐ Yes 2 ☑ No
Director	10e. Street and N					10f. Zip	777					n of What Cou	•
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Funerai	1 Never Ma	rried 2⊈ Marrie	Armed Fo	rces? 2⊠No					, Puerto	ecify Yes or N Rican, etc.)	14	Black, White,	
2	3 Widowed	4 □ Divorced	If Yes, Giv Year or D	e ates:		1 □ Yes	2½ No	Specify:			S	pecify: Whi	.te
Completed	(Spe	15. Decedent's ecify only highest	Education grade completed)		16a. Deced	lent's Usua kind of wo DO NOT us	l Occupa k done d	tion Juring mos	t of work	ing	16b. Kind	of Business/In	dustry
ign	Elementary/Sec		College (1	-4or 5+)		maker)			0	TT	
ပိ		2 e (First, Middle, La	ist)		поше	шакет		18. Mothe	r's Name	(First, Middle		Home	
ToB		Szwarcma	n				i	Leal	ı Bo	otzin			
Toe		Name/Relationship	(Type, Print)		19b. Mailir	g Address	(Street a	ind Numbe	or Or Rura	al Route Numb	er, City or T	own, State, Zip	Code)
		inczuk,	Husband					Ave				g, MD 2	
	20a. Method of Di	isposition 2 □ Cremation 3	☐Removal from	State	Place of Dispo cemetery, crer	natory or o	ther place			Date		tion - City or To	own, State
		5 Other (Spe Funeral Service Lie		Mou	nt_Leb	anon	Ceme	tery	10-2	3-2005	Adel	hi, MD	
	21. Signature of F	-uneral)Selvice Lit	sensee (a.									Home Inc MD 20904
	3a. Part1. Inter	the disease, or co	omplications that of	aused the deat								pring .	Approximate
	Immediate Cause	(Final	ily one cause on e	ach line.	ator	1 1	irne	at					Interval Between Onset and Death
	disease or condit resulting in death	ion)	aDue to	or as a conseq		1	(1 1 -0						
ı.	Sequentially list of	conditions.	b		PSis	>							
iner	If any, reading to	immediate deriving	Due to	огав а сопвыс	spirat	Lina		Pn	n	200 10			
Examin	Cause (Disease of that initiated even resulting in death	its) Last	c Due to	or as a consec	mence of):					noni			
ical E			d.	P	ul m	ona	NIP	1	Jeci	osis	,	- 1	
P	1)						
Physician/M	23b. Was deceded in the past 1			come of pregna		Ectopic pr	egnancy				230	d. Date of delive Month	ery Day Year
Sici	1 ☐ Yes 2	ENO	4□Pregn 9□Unkn	ant at time of down	leath 5	Other (sp.	ecify)					WORK	Day Teal
-		nificant condition	s contributing to de	eath but not res	ulting in the u	nderlying c	ause give	n in Part I.		23e. Did	tobacco use	contribute to the	ne cause of death?
										1 🗆	Yes 2 191	√o 3 □ Prot	oably 4 Unknown
2										24a. Was		24b. Were auto	psy findings available
þ												Drior to co	mpletion of cause of
2											ormed?	death?	2∐ No
e Completed by	25. Was case refu	erred to medical						26. Place	of Death	auto perfe 1 □ Yes	ormed? 2 No	death?	2 No
To Be Completed by	25. Was case refeaxaminer?	No			ER/Outpatien			Ir: 4□ Nu	rsing Ho	performe 5 Res	ormed? 2 No one)	death? 1 ☐ Yes Other (Specif	
To Be Completed by	25. Was case refeaxaminer?	No ath 5 Pending	28a. Date (Mon		ER/Outpatien 28b. Time of Injury	2	8c. Injury Work	r: 4 □ Nu at ?	rsing Ho	perfo 1 ☐ Yes (Check only	ormed? 2 No one)	death? 1 ☐ Yes Other (Specif	
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edical Certification: To Be Completed by	25. Was case refeaxaminer? 1 Yes 26 27. Mann	No ath 5 Pending investiga 6 Could no determin 1 Cartifying 2 Medical Ex	28a. Date (Moniton to be build) Physician: To this be administration to the building the buildi	of Injury th, Day Year) of Injury - At hing, etc. (Specification of examina	28b. Time of Injury	M 2 M eet, factory	8c. Injury Work 1 Y	4 Nu at ? Yes 2 I	No	perful Yes (Check only me 5 Resized. Describe 28f. Location (City or To	one) idence 6 [how injury o	death? 1 Yes Other (Specification of Pural Courred) Jumber of Pural Courred	y) If Route Number, tated,
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			1 - For State Registrar	State	of Maryla	and / Depa <i>Ce</i>	artmen <i>rtificat</i>	t of H e of L	ealth a Death	and Me		giene Reg. No.	05	3	35900
	Dhusisi	-	1. Decedent's Name (First, Middle,	Last)							2. Date of Dea				3. Time of Death
	Physici /Medio		WILLIAM H P	ENN						C	ctober	Day 19	200	ear) 5	2:00 A M
	Examir		4a. Facility Name (If not institution,	give street and nu	ımber)		4b. City,	Town, or	Location o	of Death		4c. 0	County of [
			14621 Claude Lai						Sprin			Mo	ntgom	nery	
ш	Funeral			i.Sex 1 🔀 M 2 🗆 F		rs. last birthday)	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. 8 Min.	B. Date of Birth (Month, Day	h /, Year)	9.	Birthpl	ace (State or Foreign
	Director		579-20-8320 Usual Residence of Decedent	· • • • • • • • • • • • • • • • • • • •		81 Yrs.				A	ugust		24 W		ington DC
	land ow		10a. State 10b. County		10c.	City, Town or Lo	cation							10	Od. Inside City Limits
	Many -f sh	ğ	MD Monts	gomery		C + 1	Con seed .								1 ☐ Yes 2 █XNo
	1 28e	Director	10e. Street and Number	zomery		Silver	10f. Zip				-	10a. Citiza	en of Wha	t Count	rv?
	h with	<u>=</u>	14621 Claude Lar				200	205							
	deat	Funeral	11. Marital Status	12. Was Dec	edent Ever in		Was Deced	905 dent of His	spanic Orig	gin? (Spec	ifv Yes or No-	Unit	ed St	America	an Indian,
9	72 hours after death with the Maryland naturel; or ttems 23a or 28e-f show Iteal Evaining must be notified at	Fu	1 ☐ Never Married 2 ☑ Married	Armed F		WTW T T	If Yes, spec 1 ☐ Yes		n, mexican, Specify:	, Риепо Н	ican, etc.)		Black, V		
21215-0036	ureli,	d by	3 ☐ Widowed 4 ☐ Divorced	Year or [Dates:		100	- W 140	эрвспу.				ipecity: (auc	asian
5	n 72	Completed	15. Decedent's (Specify only highest	Education grade completed,)	16a. Dece	dent's Usua kind of wor DO NOT us	rk done di	urina most	of working	7	16b. Kine	d of Busine	ess/Ind	ustry
12	withii ene. than	Ĕ	Elementary/Secondary (0-12)	College (5+	(1-4or 5+)			e retirea)							
9	filed Hygi ther snt,	Ö	17. Father's Name (First, Middle, La			Teach	ier		18 Mother	r's Name /	First, Middle,		catio	n	
Maryland	ld be ental ked c	0	Roy Penn								owler		amamo)		
ary	shou nd M mar umat	F	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address				Route Number	r. City or	Town. Star	e. Zin (Code)
Ž	alth a alth a 27 is		Angelina L. Penr	Spone	۵						er Spr				/
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. any Injury of other trained other than "naturel", or flems 23a or 28e-f show any Injury of other trainments event, the Medical Experiment must be notified at once.	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	-	205	. Place of Dispo	sition (Nan	ne of		Dat	te in the	20c. Loca	ation - City	or Tov	m, State
Ĕ	Pag ment ent: I		'4 □Donation 5 □ Other (Spe			ate of E	-			0-29-	2005	Silv	er S	pri	ng, MD
ä	permit. Depart Import any Inj pnce.		21. Signature of Funeral Service Lic	ensee	00	22	. Name an	d Address				aldi	Fune	ral	Home Inc.
<u> </u>	<u>v</u> ∪ = ≤ 9		, along	Wan	rell	11	008.	lew H	lampsh	nire .	Ave Sil	lver	Spri	ng l	4D 20904
			23a. Part1. Enter the disease or co shock, or heart failure. List on	poplications that is the state on the state	caused the de each line.	eath. Do not ent	er the mode	of dying	, such as c	cardiac or r	respiratory arr	est,			Approximate Interval Between
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	/Medical Examiner		resulting at death)		(or as a cons										morrons
		P.	Sequentially list conditions, if any, reading to immediate	b. Due to	(or as a cons	equenca off									
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68760,	ificate be executed g physician and as the burial-transit	edlcal		d											
89	ng ph as th		IF FEMALE:		-										
Вох	ath ce ttendi	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, ou 1 ☐ Live b	tcome of preg		Ectopic pre	onancy				23	d. Date of		
o.	that the death certii ed by the attending detached for use a	Physician/M	1 Yes 2 No	4∐Pregr 9∐Unkn	nant at time o own	f death 5	Other (spe	ecify)					Month	D	ay Year
P.O.	hat the	Ph	Part II. Other significant conditions	contributing to d	eath but not r	esulting in the ur	derking on	uleo awar	io Part I		220 Did tob		. a materille st		
Division of Vital Records,	es ign be	d by		out in the same of the same	outil out hot h	osaiting in the di	idenyang ca	iuse givei	ı iii raiti.						cause of death?
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ā		o C	25. Was case referred to medical								1□ Yes 2	∑ No	1 🗆 Y	es 2	□ No
>	/sicie s cert direct	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	☐ ER/Outpatient	2 00	Other			Check only on		70		
ō	둔 도교		27. Manner of Death	28a. Date	of Injury	28b. Time of		c. Injury a Work?	4 INUIS		5 KReside d. Describe ho			pecity)	
Ö	tending leath. Ior: After the funer	atlo	1 √Natural 5 ☐ Pending 2 ☐ Accident investigati		th, Day Year)	Injury	М		s 2 🗆 N	0					
<u> </u>	or Attendent after deatl Director:	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 28e. Place	of Injury - At	home, farm, stre	et, factory,	office		28f	Location (Str City or Town		vumber or	Rural F	Route Number,
	spitel o														
	To the Hospitel of within 24 hours at To the Funerel D completely filled in	edical	29a. Certifier (Check only one) 12 Certifying F	Physician: To the aminer: On the b	asis of exami	nowledge, death nation and/or inv	occurred a estigation,	t the time in my opir	, date and nion, death	place, and occurred	due to the ca at the time, da	use(s) an	id manner ace, and d	as stat	ed. ne cause(s)
	To the Howithin 24 h To the Fur	Med	29b. Signature and title of certifier	and man	ner stated.			License i					signed (Mo		
	+ 3 F 8		>////	7/14	120			0133					er 20		
	[0		30. Name and ddress of person	completed caus	e of death (It	am 23a) /Tuno F	terminal in the	3133				2200		,, 2	
			Andrew J. Dutka,					e #K	2 Bas	ement	Kensi	ngto	n MD	208	95
	Stat	e	31. Date filed (Month, Day, Year)			nature						<u> </u>			
	Registra	ar	OCT 2 1	ZUUD ,	BURNEY.	15 19	Be Bles Dalle								

			1 - State Registrer	ate of Maryland / De <i>C</i>	partment ertificate	of He	alth an eath		giene	5	35901
	1	50%	Decedent's Name (First, Middle, Last)					2. Date of De	ath		3. Time of Death
k	Physici /Medic		BETTY MARIE PEARL					OCTOBE	R 19, 2	2005	4:30A M
}	Examir		4a. Facility Name (If not institution, give street	and number)	4b. City, To	own, or Lo	ocation of E	Death	4c. Coun	ty of Death	
Ŀ	2	-	2323 HOUSTON STREET	7 4 (1 14-1-4-1		ITLAN		Uro la B		CE GEO	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2	7. Age (In yrs. last birthda 72 Yrs.			If Under 24 Hours	Min. (Month, Da	y, Year)	Cou	
			Usual Residence of Decedent	12				SEP. 17	, 1933	VIK	GINIA
	show	_	10a. State 10b. County	10c. City, Town or	Location					,	10d. Inside City Limits
	ath with the Maryla ; 23s or 28a-f shov	Director	MD PRINCE GEO	RGES SUITLA	ND						XXYes 2☐No
	with th		10e. Street and Number		10f. Zip C	ode			10g. Citizen of	What Coul	ntry?
	sath v	eral	2323 HOUSTON STREET	as Decedent Ever in U.S.	2 Man Danada		746	2/2	UNITE		
	after death w or itams 23£	Funeral	11. Marital Status 12. W. 1 □ Never Married 2 □ Married 1 □	med Forces? Yes 2\(\frac{\chi}{\chi}\)No	If Yes, specify	Cuban,	Mexican, P	? (Specify Yes or No Juerto Rican, etc.)	- 14. Ha	ace - Americack, White,	
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21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28a-f show the Musical Extraction and be multiped at	Completed	15. Decedent's Education (Specify only highest grade com	16a. De	cedent's Usual of work	Occupation	on ing most of	working	16b. Kind of I	3usiness/In	dustry
2	vithin ne. han .	mple	Elementary/Secondary (0-12)	llege (1-4or 5+)	. DO NOT use	retired)	ing most bi	Working			
2	e tiled within al Hygiene. I othar than '		8 TH 17. Father's Name (First, Middle, Last)	H	OMEMAKE	7	D. Mathada	None (Fine Midel)	DOME		
and	d be t	Be				18		Name (First, Middle,		me)	
Maryland	12 should be and Mental ris marked craumatic even	^C	BUD PRESTON 19a. Informant's Name/Relationship (Type, Pr	int) 19b. Ma	iling Address (S	Street and		PRESTON HE r Aural Route Numbe		State Zir	Codel
	D = C =		ROBERT A. PEARL / SO		9 PRESW			LA PLATA,			, 6000)
Jre,	of Hest itam othe		20a. Method of Disposition	20b. Place of Dis		of	DIV.	Date	20c. Location		own, State
<u><u>ĕ</u></u>	Pages nent of ant; if it ary or o		XX Burial 2 ☐ Cremation 3 ☐ Remove `4 ☐ Donation 5 ☐ Other (Specify)	ai from State	*	, ,	CEM.	10/24/05	SIITT	LAND.	MD
Baltimore,	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or other once.		21. Signature of Juneral Service Licensee					AL HOME OF			
_	20 E 8 9		1. Marsh	X .	4308 SU	ITLAN	ND ROA	AD SUITLAN	D, MD 2	20746	
П			23a. Parf1 Enter the disease, or complication shock, or heart failure. List only one cau	s that caused the death. Do not e se on each line.	inter the mode of	of dying, s	such as car	diac or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		resulting in death)	CEREBROVASCULAR	ACCIDE	T					Olisot and Death
	Examiner			Due to (or as a consequence of):							
	1 - 16	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):							
	cuted	Examiner	if any, leading to immediate Cause (Disease or injury that initiated events								
oʻ	e exectan ar	Exa		Due to (or as a consequence of):							-
8760,	icate be executed physician and the burial-transit	dical	d								
9	eath certific attending p for use as	/Me	IF FEMALE:	os outcomo of prognancy							
Вох	atten tor us	cian	in the past 12 months?		Ectopic preg					ate of delive onth	ery Day Year
P.O.	that the de led by the a detached t	ysk		Unknown	Comer (speci	y)					
υ <u>,</u>	The law requires that the death certificate has been signed by the attending page 2 should be detached tor use as	by Physician/Me	Part II. Other significant conditions contributi	ng to death but not resulting in the	underlying cau	se given ii	n Part I.	23e. Did to	bacco use con	tribute to th	ne cause of death?
rds	w require been sig should b							_ 1□Y	es XX No	3 ☐ Prob	ably 4 Dunknown
Records,	e law requ has been ye 2 shoul	Completed						24a. Was a		Were auto	psy findings available
		Com						autop: perfor1 ☐ Yes	med?	death?	npletion of cause of
Viital	ysician: Th is certificate director, pag	Be (25. Was case referred to medical examiner?					Death Check onl or	ne)		
of	di Si	^L	XXYes 2 No Hospita	1 Inpatient 2 EH/Outpati				g Home XX Resid			/)
no	ding h. Atter funer	tlon	1111	Date of Injury (Month, Day Year) 28b. Time Injury		Mork?	a 2 □ No	28d. Describe h	ow injury occur	red	
Division of	or Attanding Physician: after death. Diractor: After this certifics in by the funeral director,	fica	3 Suicide 6 Could not be 28e	Place of Injury - At home, farm,			2 110	28f. Location (S	treet and Numi	her or Rum	l Route Number,
á	ospital or A hours after unaral Dira ly filled in b	Certification:	4 Homicide determined	building, etc. (Specify)	,,			City or Tow	n, State)		
	ospital hours a unaral I ly filled		29a. Certifier XIX Certifying Physician: (Check only 2 Medical Examiner: Or	To the best of my knowledge, de	ath occurred at	the time, o	date and pl	ace, and due to the c	ause(s) and m	anner as st	ated.
	To the Hospital or A within 24 hours after To the Sunaral Dira completely filled in b	fedical	an an	n the basis of examination and/or d manner stated.							
	To COU	Σ	29b. Signature and title of certifier	- 120		icense nu		2	29d. Date signe		
Λ	0					D16	014		coto	ver 19	9,2005
K			30. Name and address of person who complete	E (ROMO PR	DEFSSIA	NAI	PLAI	E IAA	DOVER	2 M1	. 20785
	Sta	te	31. Date filed (Month, Day, Year)	Registrar's Signature	10-50	-7.16	, -, , (0000	1	. 90/83
	Registr	100	OCT 2 1 2005	Registrar's Signature	ele						

			For State Registrar	State of Ma	aryland /	Depa Cer	artment of I	lealth a	and M		giene Reg. No.		35902
	Physici /Medio		1. Decedent's Name (First, Middle, La Justiniano Ro	,	man					2. Date of De Month 10	ath 16	2005	
	Examir		4a. Facility Name (If not institution, giv Randolph Hill	Nursing			4b. City, Town, o Whea	ton	in		Mo	County of D	
	Funeral Director		5. Social Security Number 6. S NA Usual Residence of Decedent	ex 7. Age	78	Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bin (Month, Da 01.1	$\frac{1}{2}$ Year)	7 G	Birthplace (State or Foreign Country) uamo-Tolima
	Maryland a-f ehow	ctor	10a. State 10b. County Md Montgo	mery	10c. City, To		cation Spring			-			10d. Inside City Limits 1 Yes 2 No
	th with the 23a or 28	al Director	10e. Street and Number 4216 Garrett	Park Road	đ		10f. Zip Code 209	06			-	zen of What Lumbi	· ·
036	hours after death with the Maryland tural', or Iteme 23a or 28a-1 show all Examinar must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ ★ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		1	Was Decedent of I f Yes, specify Cub	lispanic Or an, Mexicar Specif y :		ecify Yes or No Rican, etc.)	ì	14. Race - A Black, W Specify: W	
9500-61212	l within 72 iene. r than "na	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)			(Give life.	dent's Usual Occup kind of work done DO NOT use retire lechani	during mos d)	t of worki	ing		nd of Busine	•
Baitimore, Maryland 2	uld be filed Mental Hyg irked other	To Be C	17. Father's Name (First, Middle, Last Faustino Rond							ria Gu			
, mar,	and 2 sho salth and h		19a. Informant's Name/Relationship (Amparo Rondon	**			ng Address <i>(Street</i> 7 Flora			neaton			
more	permit. Pages 1 and 2 should be fill Department of Health and Mental H Important: If Item 27 is marked ott any injury or other traumatic even once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		cemet	ery, crer	sition (Name of matory or other pla 70 Memoi			19/05		,	or Town, State e, Md
Bait	permit. Departr Imports any inje		21. Signature of Funeral Service Licer				5732 ge	orgi	a A	ve NW	Was.	emati hingt	on Service on,DC
	Pnysician /Medical Examiner	er.	23a. Part1. Enter the disease, or common shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate gause. Enter Unsertying.	Due to (or as a		rdia e of):	êr the mode of dyi			r respiratory a	rrest,		Approximate Interval Between Onset and Death
68760,	icate be executed physician and s the burial-transit	edical Examine	Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence								
O. Box	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal deal		Ectopic pregnanc Other (specify)	у			2	23d. Date of Month	delivery Day Year
rds, P	w requires that the been signed by th should be detache	ed by P	Part II. Other significant conditions of Hypertension,					en in Part I	*		obacco u Yes 2[_	e to the cause of death? Probably 4 🔀 Unknown
Vital Records,	The law ate has b page 2 s	Completed by	Cerebrovascula	r Accide	nt,Der	ores	ssion					prior death	autopsy findings available to completion of cause of ?
VII	Physician: r this certific ral director,	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒No	Hospital:	all ED/a		t 3 DOA Ott	000		(Check only o			
lon of	Phy this ald	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio		y 28b	. Time of Injury	28c. Inju	4 TXIAL		me 5 🗌 Resid 28d. Describe h			pecity)
DIVISION	tal or Attenders after death al Director: ed in by the	Certification:	3 Suicide 6 Could not b		ury - At home, c. (Specify)	farm, str	eet, factory, office			28f. Location (S City or Tov		d Number or	Rural Route Number,
	To the Hoepital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	(Check only 2 Medical Examone)	ysician: To the best on the basis of and manner sta	examination a	ge, death and/or inv	vestigation, in my o	pinion, dea	id place, a	ed at the time,	date and	place, and c	lue to the cause(s)
	To with To corr	Σ	29b. Signature and talle of certifier	andra	Aen	m.l	29c. Licens	576	36	1		e signed <i>(Ma</i>	onth. Day, Year)
	V		30. Name and address of person who Anuradha An		-		_{Print)} olph Roa	ad Wh	eate	on Ma∽	wlas	Бъ	
	Sta Registi		31. Date filed (Month, Day, Year) OCT 2 1 2	32 Registra	ar's Signature		ulis			on griat	1 - ai	.14	

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 0 05 35904 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 15,2005 ear HENRY LEE DONNELL ROUSE 2:04 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Prince George's Community Hospital Cheverly Prince George If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days 1₽M 2□F Hours Director 49 246-02-6036 July 17,1956 | North Carolina Usual Residence of Decedent Maryland 10a State 10c. City, Town or Location 10b Counts 10d. Inside City Limits 28e-f ehow the Medical Examiner must be notified at Bowie Prince George Director ty□Yes 2□No the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2171 Victoria Court or Itams 23a 20715 Funerai USA 12. Was Dacedent Ever in U.S. Armed Forces? 1 ™ Yes 2 □ No 1974 If Yes, Give Year or Dates to 1977 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black à 3 ☐ Widowed 4 ☐ Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other then eny injury or other traumatic awant Elementary/Secondary (0-12) College (1-4or 5+) Mail Handler Postal Service US Gov't. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Henry Rouse Queenie Rouse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) La'Tonya Rouse/daughter 7110 E. Lombard Street Hyattsville MD 20785 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 € Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 10/21/2005 Cheltenham, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility Cedar Hill Funeral Home, Inc. 4111 Pennsylvania Ave. Suitland, MD 20746 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disea e or condition resulting in death) Physician Metastatic Esorbaseal Cancer 8 mos /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Ula Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed Cause (Disease or inju-that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. the detached ģ Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 Yes 2 No 3 Probably 4 Unknown Completed Recurrent Deep Vein Thrombosis 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 Yes 2 🗓 No To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ပ 1 ☐ Yes 2 🕱 No 1 Inpatient 2 XxER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Certification: 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No filled in by the Director 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours at To the Funeral C completely filled it 29a. Certifier ical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and nanner stated. 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0037529 10-17-05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ronald Wheeler, M.D. 1221 Mercantile Lane, Largo, MD 20774 31. Date filed (Month, Day, Year) State bleve & Spell OCT 2 1 2005 Registrar

			For State Registrar	State of Marylar	nd / Depa <i>Cei</i>	artment of H	lealth an Death		giezen 05	35905
	Physici /Medic		1. Decedent's Name (First, Middle, Last) DANIEL	THOMAS	RID	INGER		2. Date of De Month	_	3. Time of Death
*	Examin		4a. Facility Name (If not institution, give s Carroll Hospital			4b. City, Town, or Westmins		Death	4c. County of Carrol	Death County
1.	Funeral Director		213-34-1427		last birthday) 67 Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of Bin (Month, Da) Jan 21,	y, Year) 1938 Ma	Birthplace (State or Foreign Country) aryLand
•	ne Maryland 8a-f show	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Carroll (ty, Town or Lo					10d. Inside City Limits 1 ☐ Yes 🏖 No
	h with th		10e. Street and Number 5900 Keysville Ro	oad		10f. Zip Code 21757			10g. Citizen of What United St	•
980	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Itams 23s or 28s-f show event, I'm Medical Evantics must be rediffed at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 ∐Yes 2 XNo If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin In, Mexican, P Specify:	? (Specify Yes or No uerto Rican, etc.)	Black, \	American Indian, White, etc. White
Maryland 21215-0036	l within 72 he jene. r than "natu	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12		(Give	dent's Usual Occup kind of work done o DO NOT use retired -employed	during most of f)		16b. Kind of Busin	ess/Industry
and	I be filed ntal Hygi ed other evant, I	Be	17. Father's Name (First, Middle, Last) Nevin L. Ridinge	r			18. Mother's	Name (First, Middle, a Marie Sh	Maiden Sumame)	
aryl	s 1 and 2 should be f Health and Mental is tam 27 is marked of other traumatic eva	ပို	19a. Informant's Name/Relationship (Type	ee, Print)	19b. Mailir	ng Address (Street		or Rural Route Number		te, Zip Code)
Baltimore, M			Frances I. Ridin 20a. Method of Disposition 1 X Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	20b. I	Place of Dispo	Keysvill sition (Name of natory or other place Union C	e) No	Date OV. 4	Maryland 20c. Location - City Keymar, M	y or Town, State
Baltin	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service License		22	. Name and Addres	ss of Facility	2005	neral Hom	 ne
	Pnysician /Medical	20	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line. METAS	th. Do not ent	er the mode of dyin	g, such as car		rrest,	Approximate Interval Between Onset and Death
	Examiner	L	Sequentially list conditions,							
8760,	sate be executed only sicien and the burial-transit	dical Examiner	Sequentially list conditions, fary leading to in-solidate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec						
.O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physicien and take a should be detached for use as the burial-transit	Physiclan/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Sc. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o 9 ☐ Unknown	al death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
rds, P.	w requires that to be the post of the post	by	Part II. Other significant conditions con	tributing to death but not res	sulting in the u	nderlying cause give	en in Part I.	23e. Did to	1/	te to the cause of death?
al Records,		Completed						24a. Was autop perfo 1 🗆 Yes	prior prior prior deat	e autopsy findings available to completion of cause of h? Yes 2 \sumbox No
f Vital	nysic lis ce direc	To Be	25. Was case referred to medical examiner?	ospital: 1 Inpatient 2	ER/Outpatien	it 3 DOA Oth	00	Death (Check only only only forme 5 Thesion		Specify)
ion of	_ = =		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Worl	∕at <br Yes 2 □ No	28d. Describe h	now injury occurred	
Division	al or Attanding s after death. Il Diractor: Afte d in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str fy)	eet, factory, office		28f. Location (S City or Tow		r Rural Route Number,
	To the Hospital or within 24 hours after To the Funaral Direction completely filled in the formula of the formu	edical	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check one) 1 Certifying Physical Examination (Check one) 1 Certifying Physical Examination (Check one) 1 Certifying Physical Examination (Check one) 1 Certifying Physical Examination (Check one) 1 Certifying Physical Examination (Check one) 1 Certifying Physical Examination (Check one) 1 Certifying Physical Examination (Check one) 1 Certifying Physical Examination (Check one) 1 Certifying Physical Examination (Check one) 1 Certifying Physical Examination (Check one) 1 Certifying Physical Examination (Check one) 1 Certifying Physical Examination	er: On the best of my known or on the basis of examination and manner stated.	owledge, death ation and/or in	n occurred at the tin vestigation, in my o	ne, date and p pinion, death o	place, and due to the occurred at the time,	cause(s) and manne date and place, and	or as stated. due to the cause(s)
	To the within 2 To tha complet	Σ	29b. Signature and title of certifier	rell-	_	29c. License	o number 6	_	29d. Date signed (N	• .
	01		30. Name and address of person who co	mpleted cause of death (Itel	m 23a) (Type, CROLL H			I	MINSTER	MD 21157
*	Sta Registr		31. Date filed (Month, Day, Year)	32. Rolling in Sign		1500			/	

State of Maryland / Department of Health and Mental Hygiene 35906 Amend Item #19a Per Inf. C849 rtificate At Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician 12:10A WILLIAM SVERRE SAND NOVEMBER 2 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner AVALON MANOR HAGERSTOWN WASHINGTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 6/2/1932 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1√XM 2□ F 73 Yrs 267-62-2703 NORWAY Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

Is marked other then "natural", or Items 23a or 28e-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Be Completed by Funeral Director BERKELEY BUNKER HILL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 577 PINNACLE DRIVE 25413 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 X X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2XXNo Baltimore, Maryland 21215-0036 Specify: Specify: 3 ☐ Widowed 4 🛣 Vorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry DELTA AIRLINES Elementary/Secondary (0-12) College (1-4or 5+) SECURITY permit. Pages 1 and 2 should be filed. Department of health and Mantal Heritangorient: if item 27 is merany injury or other 27 is merany or other 27 is merany or other 27 is merany or other 27 is merany or other 27 is merany or other 27 is merany or other 27 is merany or other 27 is merany or other 27 is merany or other 27 is merany or other 27 is merany or other 27 is merany or other 27 is merany or other 27 is merany or other 27 is merany or other 27 is merany or other 27 is merany or other 27 is merany or other 27 is merany or ot 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) TRYGRE SAND HELGA MATHIESON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Belationship (Type, Print)
SANDRA TOPM DAUGHTER 577 PINNACLE DRIVE, BUNKER HILL, WV 25413 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition NOVEMBER 1 Burial 2 Cremation 3 Removal from State SMITHSBURG, MD * 4 ☐ Donation 5 ☐ Other (Specify) SMITHSBURG CREMATORY 3, 2005 22. Name and Address of Facility
BROWN FUNERAL HOME P.O. BOX 821, 327 W. KING ST.,
MARTINSBURG, WV 25402

Approx 21. Signature of Funeral Service Licensee Navn Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury to (or as a consequence of). Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed 24 hours after death. the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to sa consequence of) Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2 ☑No 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying pause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 TYPS 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 2 100 25. Was case referred to medical examiner? 26. Place of Seath (Check only one) Hospital: Other: 4 Natursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After 5 Pending investigation 1 Matural s after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 S icide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - omici e within 24 hours a To the Funeral L 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. C. Ifier Medical completely To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1004503 MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32 Registrar's Signature State NOV 0 7 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 05 35907 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** October 19 2005 Stanley Helen 3:30 PM M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Salisbury Wicomico Wicomico Nursing Home 8. Date of Birth 10/31/1912 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□ M 2 F Months Days Hours Min 090-14-1943 Pennsylvania 92 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ortant: If item 27 is marked other then "naturel", or items 23s or 28s-f show injury or other traumatic event, the Medical Evantant must be indiffied at 1 Yes 2 □ No Director Wicomico Salisbury Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21801 900 Booth St. by Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. In maturel, or Iten important: If item 27 le marked other then "naturel, or Iten any njury or other traumatic event, the Medical Event and any not other traumatic event, the Medical Event and any night. Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white 3 □Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Shirt Factory Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
Anna Pauly Be John Shandrey 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ter 27178 Walnut Tree Rd., Salisbury, MD21801 19a. Informant's Name/Relationship (Type, Print) Kelly Anne Messick/granddaughter 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Wicomico Memorial 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/24/05 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Park Signature of Funeral Service Licensee Holloway Fuheral Home Professional Association 501 Enow Hill Rd., Salisbury, MD 21304 CFSP 2000 Approximate Interval Between Onset and Death 23a. Part1. Enter the diseas or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) AMENI **Physician** COROWARY SEASE /Medical Due to (or as a consequence of): Examiner ARDWUASCIN AR THERASCIFRONC Sequentially list currentions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical as the use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō Day Year in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) □Yes detached 9 Unknown 9 Unknow ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performes HYPOTHYROIDISM 2X No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Other: 2 Nursing Home 5 Residence 6 Other (Specify) nours after death.

nerel Director: After this filled in by the funeral di this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 7-0060515 W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maesha Thimmarayappa M.D. 614 Easternshore Dr Salisbury MD 21804 31. Date filed (Month, Day, Year) 0CT 2 1 2005 32. gistrar's Signatur State Goarle Registrar

		•	For State Registrar	State of M	larylan	d / Depa <i>Cei</i>	artment tificate	t of He e <i>of D</i>	ealth ai leath	nd Me	ntal Hy	gierre Reg. No		35908
		2	1. Decedent's Name (First, Middle, La	st)						2	Date of De	eath Da	y Year	3. Time of Death
	Physici: /Medic		Audrev Lou	ise St	alev					0	ctobe			10:10P M
1	Examin		4a. Facility Name (If not institution, giv				4b. City,	Town, or L	ocation of	Death		4c	County of Dea	ath
		43	8536 Rocky Sp	rings Roa	d			rede:					Freder	ick
	Funeral		5. \$ 220 -34-0832 ber 6. 5			last birthday)	If Under Months	1 Year Days	If Under 24 Hours	Min.	Date of Bi (Month, Di	rth a <i>y, Year)</i>	9. Bi	rthplace (State or Foreign country)
	Director		210-30-3277		66	Yrs.				A	ug. 2	0, 19	939 Ma	ryland
	pus *		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Aaryl f eho	0	Maryland Frederi	o.k	Fre	edericl	ζ.							1 ☐ Yes 2 No
	28a-	Director	10e. Street and Number	CK		- Caci Ici	10f. Zip	Code				10g, Cit	izen of What C	country?
	With With		8536 Rocky Spring	o Dd				702					ted Sta	,
	Jeath The 23	era	11. Marital Status	12. Was Deceden		.S. 13.	Was Deced	dent of His	panic Origi	n? (Specif	y Yes or N		14. Race · Arr	encan Indian,
21215-0036	be filed within 72 hours after death with the Maryland tial Hygiene. do other than "naturel", or Items 23e or 28e-f ehow event, the Midlical Examinar must be notified at	by Funeral	1 ☐ Never Married 2 ☐ Marned 3 ☑ Widowed 4 ☐ Divorced	Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates]No		fYes,spec 1□Yes 2	offy Cuban,	Mexican, Specify:	Puerto Ric	can, etc.)		Black, Wh	
Š	2 ho	Completed	15. Decedent's E			16a. Dece	dent's Usua kind of wor	d Occupati	ion	of working		16b. K	ind of Busines	s/Industry
218	within 7 ene. than "n be Med	ple	(Specify only highest grant Elementary/Secondary (0-12)	College (1-4o	r 5+)	life.	DO NOT us	se retired)	nng most c	or working				
7	d wit	P P	12			Teleph	none (Opera	tor			Pho	one Com	pany
b	be filed vital Hygie d other l	Be	17. Father's Name (First, Middle, Last)				1	8. Mother	s Name (f	First, Middle	, Maiden	Sumame)	
Maryland	should but marked	7	Sherwood Harris						Веа	tric	e Nusa	Z		
a			19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address	(Street an	d Number	or Rural F	Route Numb	er, City o	or Town, State,	Zip Code)
	is 1 and 2 if Health a Item 27 is other trai		Cathy Brown / Da	ugter	- 11.573				ings					and 21702
ore	of Hea of Hea if Item or othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State		Place of Dispo semetery, crer	sition (Nam natory or ot	ne of ther place)		Dat			ocation - City o	
Ē	Pag ment ent: ury		4 ☐ Donation 5 ☐ Other (Special	(y)		. Olive	et Cen	meter		/25/:				Maryland
Baltimore,	permit. Pages 1 Depertment of H Importent: If Ite eny Injury or ot once.		21. Signature of Funeral Service Lice	Pmity									cal Hom Lck, Md	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	ed the deat	h. Do not ent				_				Approximate Interval Between
5.	Physician		Immediate Cause (Final disease or condition	. Aa	Vav	160	1 C	colo	n	Lai	cer	_		Onset and Death 3 4e CM3
387	/Medical Examiner		resulting in death)	Due to (or a	s a conseq	uence of):								J
# ⁰	LAdminer		Sequentially list conditions,	b										
	be sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	is a conseq	uence or).								
_	cate be executed oblysicien and the burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or a	s a conseq	uence of):			_					
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87	a 년 등	dical		_ d										
9 ×	eath certifi ettending for use as	/Me	IF FEMALE:	23c. If yes, outcom	e of pregna	ancv							23d. Date of de	Playon
Вох	etten for u	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 4☐Pregnant	2 Feta	I death 3	Ectopic pro						Month Month	Day Year
o.	by the detached	ysi	1 □ Yes 2 ⊡fNo 9 □ Unknown	9□ Unknown										
Δ.	g b b		Part II. Other significant conditions	contributing to death	but not res	ulting in the u	nderlying ca	ause given	in Part I.		23e. Did	tobacco	use contribute	to the cause of death?
Vital Records,	uires sign ld be	d by									1 🗆	Yes 2	⊡ No 3□F	Probably 4 Unknown
Ö	w require been si should I	Completed									24a. Was	an	24b. Were a	utopsy findings available
Re	The fav	E G								_	auto	psy ormed?	prior to death?	completion of cause of
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\equiv	9 e	OB	examiner?	Hospital: 1 🗆 Inpa	tiont 2	ER/Outpatier	nt 3 DO	Other			Check only	-	6 □Other (Sp	an(.)
of	Phys rrthis sral di		27. Manner of Death	28a. Date of In (Month, D		28b. Time o		8c. Injury a	4 14013		d. Describe			9CITY)
o	th. : After s funer	tlor	1 Accident 5 Pending investigation		Day Year)	Injury	М		es 2∐N	0				
Division	I or Attendi after death. Director: A in by the fu	flea	3 ☐ Suicide 6 ☐ Could not b	28e. Place of I	njury - At h	ome, farm, str	eet, factory	, office		28				Rural Route Number,
ā	after after d in t	Certification:	4 Homicide	building,	etc. (Specif	y)					City or To	wn, State	9)	
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: Attencompletely filled in by the fune	edical	29a. Certifier 1 Certifying P (Check only one)	hysician: To the bes miner: On the basis and manner:	of examina	owledge, deat tion and/or in	n occurred avestigation,	at the time , in my opii	, date and nion, death	place, and occurred	d due to the at the time	cause(s , date and) and manner a d place, and du	as stated. le to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c	. License	number			29d. Da	te signed (Mor	ith, Day, Year)
	->-0		1 km			ins		0	11	86	6	Octo	ober 21	1,2005
	10		30. Name and address of person who	completed cause of	death (Iten	n 23a) (Type,	Print)		, ,	_				
_			Kanan Hudhudin	10 46R TO	Lome.	5 Tol	um	Driv	e F	100	endle	i, m	0 21	702
	Sta Regist		31. Date filed (Month, Day, Year) 0CT 2 5	2005 32. Re	strar's Signa	ature	books							

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	Physicia /Medic	al	Decedent's Name (First, Middle, La Wilma Wilma 4a. Facility Name (If not institution, gin	Diane San		dt	4b. City, Town, o	al casting of De	2. Date of De Month	Day 20,	Yes 20	US 16: 30 M
	Examin	er	, , , , , , , , , , , , , , , , , , , ,	Aiken Aven				ryville		4c. Cou	inty of D	
П	Funeral		5. Social Security Number 6.	Sex 7. Ag		last birthday)	If Under 1 Year	If Under 24 H	rs. 8 Date of Bi	rth	9 1	ecil Birthplace (State or Foreign Country)
	Director		331-38-0487 Usual Residence of Decedent	1□M 2ŽŠF	60	Yrs.	Months Days	Hours M	in. Aug. 2	25,1945		Florida
	how		10a. State 10b. County	-	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	Ba-f s	cto	Maryland Ceci	1			Perr	yville				1XXYes 2 ☐ No
	with the		10e. Street and Number	. D.O. B	_ 11		10f. Zip Code	1000		10g. Citizen		•
	eeth ne 23	era	755 Aiken Avenue	12. Was Decedent		S 13 1		1903	(Specify Ves or No		U.S.	.A. merican Indian,
213-0036	be filed within 72 hours efter deeth with the Maryland to Hygiene. A the William "stural", or iteme 23a or 28a-f show other then "satural", or iteme 23a or 28a-f show event, the Madical Examiner robat be notilied at event.	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	>		f Yes, specify Cub		(Specify Yes or No erto Rican, etc.)			hite, etc. White
בֿ ה	72 ho	ted	15. Decedent's E (Specify only highest gr	ducation		16a. Dece	dent's Usual Occup	ation	vorkina	16b. Kind o		
7	within 72 ene. then "nat	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	Registe	kind of work done DO NOT use retire ered Nurse					Care Center
7	filed w Hygien other th	S	17. Father's Name (First, Middle, Las.	Four Yea	rs	Adminis	trative Nu		rdinator lame (First, Middle			Grace, Marylan
yland	d be f) Be		y Shores				18. MO(Hers N	Wilma Da		name)	
	as 1 and 2 should bot Health and Ment item 27 is marked rother traumatic e	ဠ	19a. Informant's Name/Relationship			19b. Mailir	ng Address (Street	and Number or	Rural Route Numb		wn. State	e, Zip Code)
Mar	and 2 ealth a n 27 is		David E. Sandste	dt (Husba	nd)				lle, Mar			903
e,	iges 1 and of Heiling or other		20a. Method of Disposition 1 🗆 Burial 2 🛣 Cremation 3 [Demousl from State		Place of Dispo	sition (Name of natory or other pla	ce)	Date	20c. Locatio	on - City	or Town, State
Ĕ	mit. Pagi pertment contant: it injury o		'4 □ Donation 5 □ Other (Speci		R.	A. Ferri	s & Co.,In	c. 10	/21/05	West Ch	ester	, Pennsylvania
Baitimore,	permit. Pages Depertment of h important: If Ite any injury or of		21. Signiture of Funeral Service Lice	17112V2	EV. C	Le Le	Name and Address A. Pat	terson	& Son Fu	neral I	lome	, P.A.
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that cause one cause on each l	d the deat	h. Do not ent	er the mode of dyir	ng, such as card	iac or respiratory a	ırrest,		Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as	a conseq	uence of):						7
		-a	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as	a conseq	uence of):						
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
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68/60,	ate be executed hysicien and the burial-transit	Ical		d								
	ertifica ling ph	Med	IF FEMALE:								-	
J. BOX	e death certificate he ettending phys led for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 210 No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	death 3	Ectopic pregnancy Other (specify)	/			Date of o	delivery Day Year
т Э	hat the de id by the de detached		9 ☐ Unknowň Part II. Other significant conditions	contribution to death h	out not rec	ulting in the u	ndork ing goven an	on in Dad I	230 Did 1	lahasaa usa a	o o tesh te	to the cause of death?
cords,	w requires that the been signed by th should be detache	ed by		ooming to doding		diving in the di		on in rait i.	1 🗀			Probably 4 Unknown
ပ္ပ		Completed							24a. Was	an 24	b. Were	autopsy findings available to completion of cause of
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VITA	ician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	14					eath (Check only o	one)		
0	shys this al dii	P.	1 Yes 2 No	Hospital: 1 Inpati		ER/Outpatien		4 🗆 140131119	Home 5 Resi			pecify)
	ding Afte fune	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	y Year)	Injury	Wor	yat k? Yes 2 ∐No	28d. Describe	now injury occ	currea	
DIVISION	or Attending ifter deeth. Director: Afte in by the fune	Certification:	3 Suicide 6 Could not to	28e. Place of In	jury - At h	ome, farm, str	eet, factory, office		28f. Location (Street and Nu	mber or	Rural Route Number,
5	s efte el Dire ed in l	Cert	4 Holfficide	building, ei	ic. (Specif	y)			City or To	wn, State)		
	To the Hospitel or Attend within 24 hours efter deelt To the Funerel Director: completely filled in by the	Medical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best miner: On the basis of and manner st	if examina	wledge, death	occurred at the tirvestigation, in my o	ne, date and pla pinion, death oc	ce, and due to the curred at the time,	cause(s) and date and plac	manner e, and d	as stated. lue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. Licens			29d. Date sig	ned (Mo	onth, Day, Year)
			* # Harh	1, MD			D14	5314	!	Detob	21 2	-1,2005
	10		30. Name and address of person who			n 23a) (Type,	Print)	01	1	//		E/kton, M
	()		31. Date filed (Month, Day) Heart	1 D Slas		Novi	Lern	he sa	pure.	Itospic	9	Elking, MI
	Sta		00124	LUUD	of ser s	B.	Cools	,				

State of Maryland / Department of Health and Mental Hygiene 15 For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 23 2:50 A Kenneth H. Smiley, Jr. October 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Cecil Elkton Sun Bridge Care & Rehab Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days 1**∑**M 2□F Michigan 30,1928 76 369-22-3672 December Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County 10a. State 27 is marked othar than "natural", or itams 23a or 28e-f ahow traumatic avant, ito Madical Examinat / ust be notified at 1 ☐ Yes 2 No Director Elkton MD Cecil 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 124 Normira Avenue 21921 USA Pages 1 and 2 should be filed within 72 hours after death 1 nent of Health and Mental Hygiene. Int: If itam 27 ia marked othar than "natural", or itams 23 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 □ No If Yes, Give Year or Dates: WW 11 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: δ 3 Widowed 4 Divorced White ted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Complet College (1-4or 5+) Elementary/Secondary (0-12) VP of Security Banking 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Patricia Wilson Kenneth H. Smiley, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If itam 27 is any injury or other tra Lauren M. Strohm/daughter 166 Glen Riddle Road, Media, PA Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 Cremation 3 Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) 10-25-2005 West Chester, PA Ferris & Company 22. Name and Address of Facility R.T. Foard Funeral, P.A. 21. Signature of Funeral Service Licenses 111 S. Queen Street, Rising Sun, MD e unasa 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician EREBRAL VASCULAR ACCIDENT disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. The law requires that the death certificate be Physiclan/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospitel or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifica 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification; 1 Natural 2 Accident 5 Pending investigation 1 🗌 Yes 2 No 6 🗌 Could not be 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29c. License number 29d. Date signed (Mgnth, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Main St., 313 W. Gary A. Beste, MD Newark, DE 31. Date filed (MO) (7 Pay2 Year) 2005 Registrar's Sign State Registrar

			1 - For State Registrar	State of Mar		artment of He rtificate of L		ental Hygien Reg. N	6002	35911
	Physici	an	Decedent's Name (First, Middle, Last)	1 -1-					ay Year	
	/Medic	al	4a. Facility Name (If not institution, give si	bridge treet and number)		4b. City, Town, or	Location of Death		.7, 2005 c. County of Dea	
			Continum Care at S	ykesville		Sykesvi			Carr	
	Funeral Director		212 32 3730	M 2□ F 7. Age (i	n yrs. last birthday) 57 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Yea Feb 22, 19	9. Bia 948 Ma	rthplace (State or Foreign country) aryland
	/land		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or Lo	ocation				10d. Inside City Limits
	e Mar	ctor	Maryland Carroll	l			Hampstea	d		1 ☐ Yes 2 ☑ No
	th with th	al Director	10e. Street and Number 1525 Main Street			10f. Zip Code	21074	10g. C	Citizen of What C USA	country?
36	77 hours after death with the Maryland *naturel*, or Items 23e or 28e-f show edical Examerat has be multiked at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	Was Decedent Even Armed Forces? Was 2 □ No If Yes, Give Year or Dates:	Viet	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☑ No	spanic Origin? (Spec n, Mexican, Puerto R Specify:	cify Yes or No- lican, etc.)	14. Race - Am Black, Whi Specify:	
90-10	2 hour	ted k	15. Decedent's Educ	ation	Nam	dent's Usual Occupa	tion	16b.	Kind of Business	
121	d within 7 jiene. r then °n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		dent's Usual Occupa kind of work done d DO NOT use retired) NStruction		g	Constru	ction
d 2	filed Hygir ther ant, I		17. Father's Name (First, Middle, Last)		COI			(First, Middle, Maide		
/lan		To Be	David S. Stockbr	idge, Sr.			Walter	ne Shows		
Maryland 21215-0036	and and is m		19a. Informant's Name/Relationship (Type Joel Stockbridge,			-		Route Number, City		Zip Code)
	s 1 and f Health item 27 other tr	1 7	20a. Method of Disposition		20b. Place of Dispo	sition (Name of	Da	arks, MD 2	Location - City or	r Town, State
imo	00-		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	-	natory or other place ad UM Cem.		/2005 B	utler, 1	MD .
Baltimore,	permit. Pag Department Importent: eny injury c		21. Signature of uneral Service License	M9072	?3 , 22	2. Name and Address 934 South		line Fune Hampstea		
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	cations that caused the cause on each line.	e death. Do not ent			respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a c	onsequence of);	Synde	one			Weeks
	Examiner		a	Ala	do do a	buse				Years
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence of):					
Ć,	ificate be executed g physician and as the burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a c	onsequence of):					
68760,	icate be physicia the bur	edical	d.							
Box 68			230. Was decedent pregnant	Bc. If yes, outcome of p		Ectopic pregnancy			23d. Date of de	*
P.O. B	it the deal by the att tached fo	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at tim 9☐ Unknown		Other (specify)			Month	Day Year
	The law requires that the death cert ate has been signed by the attending bage 2 should be detached for use	by	Part II. Other significant conditions cont	tributing to death but r	not resulting in the u	nderlying cause give	n in Part I.		1.0	to the cause of death?
I Records,		Completed						24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of s 2 No
Vital	sician: T certificat irector, pa	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	C T EB/Outpation	Othe	26. Place of Death		0.50	- ''
of	Attending Physician: or death. ector: After this certific. by the funeral director,	-	27. Manner of Death	28a. Date of Injury (Month, Day Y	2 ER/Outpatier 28b. Time o		at 28	e 5 Residence		eciry)
Division	Attendin death. ctor: Af y the fur	catlo	1 Accident 3 Suicide 6 Could not be			M 1 1 Y	'es 2□No			
Divi	spitel or Attendours after death ours after death heral Director: , filled in by the f	Certification:	4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm, str Specify)	eet, factory, office	21	Bf. Location (Street a City or Town, Sta	na Number or H te)	lurai Houte Number,
	To the Hospitel or within 24 hours after to the Funeral Dirth completely filled in V	edical	29a. Certifier (Check only one) Certifying Physic Certifying Phys	ician: To the best of n er: On the basis of ex and manner stated	amination and/or in	h occurred at the time vestigation, in my op	e, date and place, ar inion, death occurred	nd due to the cause(d at the time, date ar	s) and manner a nd place, and du	s stated. e to the cause(s)
	with Com	Σ	29b. Signature and title of certifier	44.0		29c. License			ate signed (Mon	•
,	E +		30. Name and address of person who con	mpleted cause of deat	h (Item 23a) (Type,	Print)	WY 8 (5	37 10	1118103	
-	\$ \$		Willow Ko	295 Sto	ser Aug	5+307	Wester	inster	MDZ	21157
	Sta Registi		31. Date filed (Month, Day, Year) OCT 2 0	32. Register's 2005	www. K	Spelle				

			For State Registrar	State of	Maryland / Depa <i>Ce</i>	artment of H			2005 3	35912
			Decedent's Name (First, Middle	e, Last)				2. Date of Death		3. Time of Death
	Physicia /Medic		Harry	С.	Simp	son		October	19 2005	6:55 a M
	Examin		4a. Facility Name (If not institution	, give street and numb	er)	4b. City, Town, or	Location of Death		4c. County of Death	
			4916 Hine Dri			Shady			Anne Arur	ndel
	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. last birthday) 57 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) Cou	
	Director	-	313-52-2147 Usual Residence of Decedent	XX	57 Yrs.			March 1	1,1948 Mai	yland
	land ow	ŀ	10a. State 10b. County		10c. City, Town or Lo	ocation	····			10d. Inside City Limits
	Mary -f sh	ţ	MD Anne	Arundel	Shady	Side				1 □Yes 2 XNo
	r 28a	irec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	ntry?
	th wit	aiD	4916 Hine Driv	e		20	764		USA	
	ems ems	iner	11. Marital Status	12. Was Decede Armed Force	ent Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
36	within 72 hours after death with the Maryland ene. than "teturel", or Items 23a or 28a-f show the Medical Examinar must be inclilied at	by Funeral Director	1 Never Married 2 Marr	ied 1X Yes 2 If Yes, Give	☐ No	1 ☐ Yes 2X No	Specify:			Thite
ë	hours tural		3 Widowed 4 Divorced			dent's Usual Occup	ation		6b. Kind of Business/Ir	duated
7	in 72 "na" r	ojet	(Specify only highes	st grade completed)	(Give	kind of work done of DO NOT use retired	during most of work	ing	ob. Killa of Busillessyll	dustry
21215-0036	l with liene. r thau	Completed	Elementary/Secondary (0-12)	College (1-4		neer			Railroad	
힏	al Hyg	Bec	17. Father's Name (First, Middle,	Last)			18. Mother's Nam	e (First, Middle, M	aiden Sumame)	
/lai	Menta	10	Harry Simpson,	Jr.			Dorothy	Evans		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show amportant: If item 27 is marked other than "natural; or Items 23a or 28a-f show appring injury or other traumatic event, the Medical Examinal must be notified at once.		19a. Informant's Name/Relations						City or Town, State, Zij	Code)
e,	1 and 4ealth 9m 27 ther t		Christine Simp 20a. Method of Disposition	son (Wire)	20b. Place of Dispo	Hine Dr			20/64 Oc. Location - City or T	own State
יסר	ages nt of h		1 ☐ Burial 2XX remation		ate cemetery, cre	matory or other plac	(e)			
Baltimore,	artmel ortant injury		' 4 □ Donation 5 □ Other (S	1	the second secon	Crematory 2. Name and Addre		0-2005 1	Baltimore,	MD
l Ba	Depar Impo any ir		Datas &	1 all		Hardesty 12 Ridge	Funeral Ly Avenue	• Annapo	lis, MD 214	01
Ι.			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau only one cause on eac	sed the death. Do not en th line.			or respiratory arres	st,	Approximate Interval Between Qnset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	LUN	y cav	rcev			Smis
ļ,	/Medical Examiner		rooming in dodain)	Due to (or	as a consequence of): -					
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	uted d ansit	Examine	Cause (Disease or injury that initiated events	S .						
o	e exec en an irial-tr		resulting in death) Last	Due to (or	as a consequence of):					
8760,	death certificate be executed e attending physicien and of for use as the buriat-transit	dicai		d						
9	leath certific attending p	/Mec	IF FEMALE:	23c. If yes, outco	mo of prognancy	y	0.000			
Вох	attend for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birt	h 2 Fetal death 3	∃Ectopic pregnancy ∃ Other (specify)	1		23d. Date of deliv Month	ery Day Year
o.	that the de ad by the detached	iysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknow						
σ.		by Pł	Part II. Other significant condition	ons contributing to dea	th but not resulting in the u	ınderlying cause gıv	en in Part I.	23e. Did toba	acco use contribute to t	he cause of death?
rds	- N D	ed b						1 es	2 □ No 3 □ Proi	pably 4 Unknown
Record	e law requ has been je 2 shoul	ompieted						24a. Was an	24b. Were auto	ppsy findings available impletion of cause of
Ä	e de	Com						perform		
Vital	ician: Th certificate rector, pag	Be (25. Was case referred to medica examiner?					h (Check only one)	
of \	88 8	၉	1 Yes 2 □ No	Hospital: 1 ☐ Inp			4 Nursing Ho		ce 6 Other (Special	(y)
	ttending Phydeath. Hor: After thi	ion:	27. Manner of Death 1 Natural 5 ☐ Pendir	19	Injury 28b. Time of Injury	Wor	y at k? Yes 2 □ No	28d. Describe hov	vinjury occurred	
Division		icat	2 Accident investi 3 Suicide 6 Could	not be	f Injury - At home, farm, st		163 2 140	28f. Location (Stre	eet and Number or Run	al Route Number.
Di∨	- 0	Certification:	4 Homicide determ	building	, etc. (Specify)	1001, 120101), 011100		City or Town,	State)	
	To the Hospitel of within 24 hours af To the Funeral D completely filled in	ledical C	29a. Certifier (Check only one) 1 Certifyir 2 Medical	ng Physician: To the b Examiner: On the bas and manne	est of my knowledge, deat is of examination and/or in r stated.	th occurred at the tire tire tire to the t	me, date and place, pinion, death occur	and due to the cau red at the time, dat	use(s) and manner as s e and place, and due t	stated. the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifie			29c. Licens	e number	29	d. Date signed (Month,	Day, Year)
			> 大孝	elouil	7,000	U	14838		10/19/20	XII -
_			30 Name and address of person	i. Selo	uich, m	Print) 90	U BRIT	gate,	10/19/20 124000p	olis Md.
	Sta Registr		31. Date filed (<i>Month</i> , <i>Day</i> , <i>Year</i>)	2005 P. Reg	gistrar's Signature	de				

			For State Registrar	State of Ma	aryland		artment rtificate			and Me		giene Reg. No	\mathbf{U}		35913	
			1. Decedent's Name (First, Middle, Last	")						2	Date of Dea	ath Day	V Y6	ar	3. Time of Deat	h
	Physici: /Medic		Miriam Schoen	nbrun							Octobe		, 200		11:15A	M
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, 1	Town, or	Location o	of Death		4c.	County of [)eath		
			Kensington Park As	ssisted L	iving				gton				Montg	ome	ry	
	Funeral		Social Security Number 6. Se		e (In yrs. las		If Under Months	1 Year Days	If Under Hours	Min.	. Date of Birt (Month, Da	y, Year)		Birthpl	ace (State or Fore	ыgп
	Director		121 12 3702	M 2QF	84	Yrs.				S	ept. 4	, 19	21 N	ew_	York Cit	У
	and w	1	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	ocation							11	Od. Inside City Lin	nits
	eho	5			77										1∏Yes 2□	No
	the M	ect	Maryland Montgome	ery	Kens	ingto	10f. Zip	Code				10a Cit	izen of Wha	t Cour	X	
	a or	Funeral Director	3616 Littledale Re	nad.				895				-	S. A.			
	eath	era	11. Marital Status	12. Was Decedent	Ever in U.S.	13.			ispanic Ori	ain? (Speci	fv Yes or No		14. Race -	Americ	an Indian,	
10	ter d	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 📉					n, Mexicar	i, Puèrto Ri	fy Yes or No- can, etc.)	İ	Black, \			
936	urs a	à	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2	X No	Specity:				Specify:	W	hite	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or iteme 23a or 28a-f ehow tra Madical Examiner must be notillied at	Completed	15. Decedent's Ed			16a. Dece	dent's Usua kind of wor	l Occupa	ation	t of working		16b. K	ind of Busin	ess/Inc	lustry	
215	hin 7	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or t	5+>	life.	DO NOT us	e retired))	t di working	'					
2	ar th	ГО		5+		I	eache!	r					Educa	tio	n	
nd	at Hy	Be (17. Father's Name (First, Middle, Last)								First, Middle,		Sumame)			
<u>Na</u>	Meni arke	ဥ	Abraham Spind								oinste					
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene if Health and Mental Hygiene item 23 to marked other than "natural", or Iteme 23a or 28a-f show item 27 to marked other than "natural", or Iteme itements event. Ite Madical Experiment must be notified at		19a. Informant's Name/Relationship (7				•	1			Route Numbe					
2	and ealth m 27		Barbara Glickman	- Daugnte					Stre	et, Ci		_		•	nd 20815	
ore	H ita		20a. Method of Disposition A Burial 2 □ Cremation 3 🔯	Removal from State	cen	netery, cre	sition (Nam matory or ot	her plac				20c. L	ocation - Cit	or 10	wn, State	
Ë	Page Hand		`4 □ Donation 5 □ Other (Specify)	Ca1		on Cem			0/19/					New York	ζ.
Elementary/Secondary (0-12) College (1-4or 5+) 5+ Teacher 17. Father's Name (First, Middle, Last) Abraham Spindler 19a. Informant's Name/Relationship (Type, Print) Barbara Glickman — Daughter 20a. Method of Disposition Abraham Spindler 20a. Method of Disposition Abraham Spindler 20a. Method of Disposition Abraham Spindler 20b. Place of Disposition (Name of cemetery, crematory of other place) 21. Signature of Funeral Service Licensee 22. Name and Address (Danzansky—God) 23a. Part 1. Enter the disease, or complications that caused the feath. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line.								ille	Pike,	Rockv	ille	napels , Mar	, I yla	nc. nd 2085	2	
	434.00	1	23a. Part1. Enter the disease, or comp	olications that caused one cause on each li	d the ath.	Do not en	ter the mode	e of dyin	g, such as	cardiac or	respiratory ar	rrest,			Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	_	entia										Onset and Death	1
	/Medical		resulting in death)	Due to (or as	a conseque	ence of):										
	Examiner		Sequentially list conditions		iratio		eumoni	.a								
	D :=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Under in Cause (Disease or injury	Due to (or as	a conseque	ence of):										
	acute and trans	Examiner	that initiated events resulting in death) Last	c. Anei												
30,	certificate be executed tding physician and use as the burial-transit	û	rosaking in doddin Eddi	Due to (or as												
8760,	physic the b	Physician/Medical		d. <u>нур</u>	ertens	31011								-		
9	es that the death certific. Igned by the attending p be detached for use as t	Me	IF FEMALE:	23c. If yes, outcome	of orognon											100
Box	death co	lan/	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth	2 🗍 Fetal d	leath 3[Ectopic pre						23d. Date o Month		Day Year	
_	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∏Pregnant a 9∏Unknown	t time or dea	itn 5 [Other (spe	эспу)								
P.0	requires that the veen signed by th hould be detache	P	Part II. Other significant conditions of	ontributing to death t	out not result	ting in the L	inderlying ca	ause div	en in Part I		23e. Did t	obacco	use contribu	te to th	e cause of death?	?
Records,	signe d be	Completed by	Atheroosclerotic	-				•			10,	Yes 2	ŪgrNo 3[_ Prob	ably 4 □Unkno	own
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ec	e faw has b	пр									24a. Was autop	osv	prig	r to cor	osy findings availa npletion of cause	of
A F	sicien: The law certificate has b irector, page 2 s											rmed? 2 No	1 0	Yes	2 No	
of Vital	ding Physicien: After this certifica funeral director,	Be	25. Was case referred to medical examiner?	Hospital:				. Oth			Check only o					
of	Phys this al dir	၉	1 Yes 2 No 27. Manner of Death	1 Inpati		R/Outpatie 28b. Time o	TOTAL TRANSPORTED BASES	A			e 5 🗆 Resid			Specify	/)	-
n	ling After fune	lo	1 Natural 5 ☐ Pending	28a, Date of Inju (Month, Da	y Year)	Injury	м	8c. Injun Worl	k? Yes 2.⊟		d. Describe	now mya	y coodings			
isi	Attending r death. ector: After y the fune	Ical	3 Suicide 6 Could not be		iury - At hom	ne. farm. st					If. Location (Street ar	nd Number o	or Rura	l Route Number,	
Division	after Direction by	Certification:	4 Homicide determined	28e. Place of In building, e	tc. (Specify)			, 011100			City or Tox	wn, State	9)			
_	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	O E	29a. Certifier V Certifying Ph	ysician: To the best	of my know	iedge, dea	h occurred:	at the tin	ne, date ar	nd place, an	id due to the	causels	and manne	ar as si	ated.	
	24 h 24 h Fur etely	edical		niner: On the basis of and manner st	of examination											
	oth ompl	Me	29b. Signature and title of certifier	1 0 0			29c	. Licens	e number			29d. Da	te signed (A	fonth,	Day, Year)	
			1 Hay	Most.				D53	691			Octo	ber 1	7,	2005	
	Q		30. Name and address of person who	completed cause of	death (Item 2	23a) (Type	Print)									
			Dr. Ajay R					1 7	Roths	odo .	Maryla	n J	20017	1.0	61.	
	St	ate	31. Date filed (Month, Day, Year)	32 Regist	rar's Signatu	re A	arke		berne	sua, .	пагута	ınd —	-∠Uŏ1/	-10	04	
	Regist		CCT 2 4 2	005	20 10	- Jay										

			For State Registrar	State of Ma	arylan		rtment of F		nd Mental Hy	giene Reg. No.	005	359	14
	Physicia	an	1. Decedent's Name (First, Middle, Last)	_					2. Date of D Month	Day	Year	3. Time of	
	/Medic	cai	ARNITA 4a. Facility Name (If not institution, give st.		MMS		4b. City, Town, o	r Lagation of			12,200 County of Oea)P ™
	Examin	ier	Laurel Regional	Hospit			Lau	rel		Pr	ince	George	
	Funeral Director		227 07 1303	M 2 ☐ 7. Age	96	ast birthday) Yrs.	If Under 1 Year Months Days	Hours	8. Date of B Min. Month, D June 2	orth 8 , 19 8 , 19	9. Bin Co Ma	thplace (State of ountry) aryland	r Foreign
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City	r, Town or Lo	cation					10d. Inside Cit	ty Limits
	Mary 9-f sh	tor	MD Anne Aru	ndel		Han	over					1 TYes	2 □ No
	ith the or 284	Olrec	10e. Street and Number				10f. Zip Code			10g. Citiz	zen of What Co	ountry?	
	s 23e	eral	7455 Race Road	2. Was Decedent I	Cuerio II	5 12 1		21076	:-2 (C		U.S.A.		
20	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Mental Hygiene. Importent: If them 21 is marked other than "netural" or Itams 23e or 28e-f show any Inhury or other treumatic event, Ita Medical Exaction must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ◯ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2\tag{Y} If Yes, Give Year or Dates:			Yes, specify Cuba	an, Mexican, Specify:	in? (Specify Ye <i>s</i> or N Puerto Rican, etc.)	1 _	4. Race - Ame Black, Whit Specify: B	te, etc.	
5	72 hou		15. Decedent's Educa	ation		16a. Deced	ent's Usual Occup	ation	of working	16b. Kin	nd of Business	/Industry	
Ž	ithin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	+)		kind of work done OO NOT use retired						
7	filed w Hygiei ther ti	e Col	10th 17. Father's Name (First, Middle, Last)			Nurs	sing Ass		Nt 's Name <i>(First, Middl</i> i			ty of I	AD
yland	Mental Merked o	To Be	William H. Lo					Ma	ry E. Br	ewer			
	nd 2 sh elth and 27 Is m ir treum		19a. Informant's Name/Relationship (Typ Herbert Simms,				-		or Rural Route Num nover, M			Zip Code)	
baltimore,	of Hee		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	20b. P	lace of Disposemetery, cren	sition (Name of natory or other place	ce)	Date	20c. Loc	cation - City or	Town, State	
Ě	Pag Minent My		`4 □Donation 5 □Other (Specify)		St.		Cem.	, ,	/20/05		over,		
0	permit Depar Impor any In	1	21. Signature of Funeral Service Liens	marel	u				Snowden gton St				
į	nysician		23a. Part1. Enter the disease, or complic shock, or heart failura. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each lir	10.		er the mode of dyin			arrest,		Approximate Interval Bety Onset and I	ween
	/Medical _. Examiner			Due to (or as RENAL		,							
	nsit	nlner	Sequentially list conditions, if any loading to intredict cause. Enter Underlying Cause (Disease or injury that initiated events	ATRIAL			ATION						
0/00,	cate be executed physicien and s the burial-transit	dical Examin	resulting in death) Last	Due to (or as			RT FAIL	URE					
	rtificat ng phy as th	0	IF FEMALE:										
O. BOX	The law requires that the death certific its has been signed by the attending page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Feta	death 3	Ectopic pregnancy Other (specify)	/		2	3d. Date of de Month		/ear
ν, Γ	es thet thighed by	by Phy	Part II. Other significant conditions cont	ributing to death b	ut not resi	ulting in the ur	nderlying cause giv	en in Part I.				o the cause of d	
ecords,	requir	eted							_	Yes 25		robably 4 🗆	
i rec	The lar	Completed							24a. Wa auto per 1 🗆 Yes	opsy formed?	24b. Were as prior to death?	utopsy findings a completion of ca No	available ause of
VII	sician certifi irector	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	20	55/0-11	Oth		of Death (Check only				
ō	g Phy er this eral d	H-	27. Manner of Death	1 Inpatie 28a. Date of Inju (Month, Da	ry	ER/Outpatien 28b. Time of	28c. Injur	y at	sing Home 5 Res			ecity)	
VISION	ath. art. Aft	atio	1 Natural 5 Pending investigation	(Worth, Da)	y rear)	Injury	M 1	x? Yes 2□N	0				
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Dijector: After this certifical completely filled in by the funeral director, it	Cer ification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc.	ury - At ho c. <i>(Specif</i> y	ome, farm, stre	eet, factory, office		28f. Location City or To	(Street and own, State)	Number or Re	ural Route Num	ber,
	ne Hospi ne Funer tetely fill	Medical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin	cian: To the best er: On the basis of and manner sta	f examina	wledge, death tion and/or inv	occurred at the tir restigation, in my o	ne, date and pinion, death	place, and due to the occurred at the time	e cause(s) : e, date and	and manner as place, and due	s stated. e to the cause(s)
		Me	29b. Signature and title of certifier				29c. Licens				signed (Mont		
	4		Rita Visl	rahi	(1)		D2	025		10	//3/	2005	
			30. Name and address of person who cor	npleted cause of d	eath (Item	23a) (Type,	Print) 45em R	20 #9	51 220 Lau	rel	M	2070	7
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) OCT 2 4 200	32. Registr	ar's Signa	ture	de						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year KERSTIN ANNA-BRITT MAHRBERG SJOREN /Medical October 0 16 2005 11:00 P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Days Hours 1 □ M 2 🕅 F Director 85 Yrs 311.32.7953 18, 1920 Sweden Jan. Usual Residence of Decedent the Maryland 10a State 10h Count 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. "Internet: If item 271s marked other then "neturel", or items 23a or 28e-f show any nitury or other treumatic event, the Medical Examination and buildfield and once. 10d. Inside City Limits Directo 1 X Yes 2 □ No Maryland Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8016 Glenside Drive 20912 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 À 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 Years Nurse/Physical Therapist Healthcare Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame Johan Edvard Mahrberg F. Anna Wiberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marianne Scriven/Daughter 8016 Glenside Drive, Takoma Park, Maryland 20912 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Fort Lincoln Crematory 10/22/05 ^¹ 4 □ Donation 5 □ Other (Specify) Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
HINES-RINALDI FUNERAL HOME, INC.
11800 New Hampshire Avenue, Silver Spring, MD Na 23a. Part1. Enter the disease, or complications that caused that leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failude. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consec **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examine Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Box 68760 Physician/Medical the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown þ Part II. Other sig a icant co ditions contributing death but not resiliting in the underlying cause given in Pa 23e. Did tobacco use contribute to the cause of death? Records, þ 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 : certificate has performed No autopsy 1 Yes Division of Vital 2 🗌 No 1 ☐ Yes Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes ZNo 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After Certification: 28d. Describe how injury occurred Natural 2 Accident 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide n 24 hours the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and ad less of person who completed cause of death (Item 23a) (Type, Print) Nasreen Mustafa Kango, M.D, 7610 Carroll Avenue, Takoma Park, Maryland 20912 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

				partment of Health and Mertificate of Death	ental Hygien		16	
	Physicia		1. Decedent's Name <i>(First, Middle, Last)</i> Joseph Martin Szymanski		2. Date of Death OCTOber			
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death		
	Funeral		Union Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 222601747 ★3★ 2□ F 40 Yrs.	Elkton If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year Nov. 16,	9. Birthplace (State of Country)		
	Director		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation	NOV.10,	1964 Delawar		
	e Maryla a-f ehor	ctor	Maryland Cecil Elkto				2X No	
	3s or 28	ii Director	10e. Street and Number 10 Woods Way	10f. Zip Code 21921	10g. C	itizen of What Country? nited States		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mental Hydiene. Important: It litem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'th Medical Examina must be notified at Once.	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ②No 1 □ Yes 2 ②No 1 □ Yes 2 ②No 1 □ Yes 2 □ Yes Give Year or Dates:	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes 2 ☑ No Specify:	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White		
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d 21	filed wil Hygien other th	Be Con	12 Ca 17. Father's Name (First, Middle, Last)	rpenter 18. Mother's Name	(First, Middle, Maide		n	
rylan	nould be d Mental narked natic ev	To B	Edward P. Szymanski 19a. Informant's Name/Relationship (Type, Print) 19b. Mail	Mary	y M. Kav			
, Ma	and 2 s eaith an m 27 is r		Mary Szymanski/Mother 10	Woods Way, Elk	ton Mary	land 21921		
Baltimore,	Pages 1 nent of H ant: It Itel ury or oth		20a. Method of Disposition 1 □ Burial 2 M Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify) Cremat	ematory or other place) Octo	oer24 _H	Location - City or Town, State ockessin Delaware		
Balt	permit. Departr Importa any Inj			22. Name and Address of Facility Cro 27 South Main S			01	
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final	nter the mode of dying, such as cardiac o	r respiratory arrest,	Interval Bet	ween	
	Physician /Medical Examiner		disease or condition resulting in death) a. Due to (or as a consequence of):	mest			nstruction me) ugh n, State, Zip Code) d 21.921 - City or Town, State essin aware I Home st MD 21.901 Approximate Interval Between Onset and Death ate of delivery onth Day Year htribute to the cause of death? 3 Probably 4 Vunknown Were autopsy findings available	
	ad sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	nal failure				
ö, Nv	cate be executed physicien and the burial-transit	i Examiner	resulting in death) Last C. Due to (or as a consequence of):					
68760,	tificate b ng physic as the b	ledicai	d					
.O. Box	ne death cei the attendir thed for use	by Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day	Year	
<u>α</u>	sign d be	ed by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of c	e ^t	
of Vital Records,	The law ate has b page 2 s	Completed	Sergue disorder		24a. Was an autopsy performed?	prior to completion of c death?	available cause of	
f Vita	ding Physician: h. After this certific funeral director.	To Be	25. Was case referred to medical swaminer? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	26. Place of Death ent 3 DOA Other: 4 Nursing Hon	(Check only one) ne 5 ☐ Residence	6 ☐Other (Specify)		
o uo	ing After une		27 Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation		8d. Describe how inju	ury occurred		
Division	in the c	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, larm, s building, etc. (Specify)	street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Num te)	nber,	
	Hospits 4 hours Funera tely fille	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or i and manner stated.	ath occurred at the time, date and place, a investigation, in my opinion, death occurre	and due to the cause(ad at the time, date ar	s) and manner as stated. nd place, and due to the cause(s	5)	
	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month, Day, Year)		
,	Y		30. Name and address of person who completed cause of death (Item 23a) (Type	B. Print) 202 (umair	Str. Elkk	3)	
	Sta Registi		31. Date filed (Month, Par. Ygar) 1 2005 32. fegistrar's Signature		- CACH	·		

			1 - For State Registra-AMEND #23		of Maryland DB I0/21 PER PHYS	Depa 1/05 er	rtment tificate	of H	ealth a Death			3	005	3591	17
	Physici	an	1. Decedent's Name (First, Middle								2. Date of De Month	Day	_	3. Time of	М
	/Medic Examin		Jane Ann Shor 4a. Facility Name (If not institution		umber)		4b. City, To	own, or	Location of)ctobe		2005 County of Deat	3:12	Α"
- √		***	Southern Maryl				Clin							George:	
	Funeral Director		5. Social Security Number 131–20–5603	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Months I	Year Days	If Under 2 Hours	Min.	B. Date of Bi (Month, D	ay, Year)		thplace (State of ountry)	
	D D		Usual Residence of Decedent					1			Januar	y 30	, 1928	New You	
	filed within 72 hours after death with the Maryland Hygiene. Inter then "naturel", or items 23a or 28a-f ehow ent, it a Mudical Examination indified at	2	10a. State 10b. County			Town or Lo	_							10d. Inside Cit	
	288-1	Directo	MD Charl 10e. Street and Number	.es	В	ryans	Road 10f. Zip C	ode				10a, Cit	izen of What Co		
	th with	a Di	7289 Carroll D	rive				0616	5			USZ		, .	
	tems terms	Funeral	11. Marital Status	12. Was Dec	cedent Ever in U.S. orces?	. 13. V				in? (Spec , Puerto R	ify Yes or Nican, etc.)	0-	14. Race - Ame Black, Whit		
2	rs afte	by Fi	1 ☐ Never Married 2 ☐ Mar 3√2 Widowed 4 ☐ Divorced	III YAS CI	2 No live No	1	☐ Yes 2				,		Specify:		
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ar y	ges 1 and 2 should be filed within 72 hours after death with the Marylan to f Health and Mental Hygiene. If item 27 is marked other then "natural", or Items 23a or 28s-f show or other traumatic event, the Modical Examinations to collined at	-	19a. Informant's Name/Relations			19b. Mailin	g Address (S	Street a				er, City o	or Town, State, 2	Zip Code)	
∑ ໜົ	ealth m 27		Nancy McCarle	y (daught		263 I	rift	Woor	Lan				20688		
2	permit. Pages 1 and Department of Healt Important: if Item 2 any injury or other anges		20a. Method of Disposition 1 XBurial 2 ☐ Cremation		State cen	netery, cren	sition (Name natory or other	er place	1	Da			ocation - City or		
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	Physician /Medical systems of physician physician and physician and physician in the prijal-transit physician physic	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Last Cause (Disease or injury that initiated events resulting in death) Last ABDOM A OBSTRUCTOW CAUTESTINES Onset at Consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										Approximate interval Betv Onset and D	ween	
Ď :	The law requires thet the death certificate be its hes been signed by the ettending physicis page 2 should be detached for use as the bur	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown		B⊟Ectopic pregnancy Diagram Other (specify)					23d. Date of delivery Month Day Year			'ear		
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	cian: ertifici ector,	Be	25. Was case referred to medica examiner?					1		of Death	Check only				
0 10	To the Hospitel or Attending Physician: The law within 24 burus elter death. To the Funeral Director: Attenthis certificate hes completely filled in by the funeral director, page 2 to proper and the funeral director, but the funeral director, page 2 to the funeral director.	ation; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendir 2 Accident investi	28a. Date (Mor		R/Outpatien 8b. Time of Injury		Other	4 🔲 Nur	28	e 5 Res		6 □Other (Spec y occurred	cify)	
DIVIS	itel or Atte	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 286. Place	e of Injury - At hom ding, etc. (Specify)	e, farm, stre	eet, factory, o	office		28	Sf. Location (City or To	Street an wn, State	d Number or Ru	iral Route Numb	ber,
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	N N N N N N N N N N N N N N N N N N N		29b. Signature and title of certifie	п			D -	_] S	number	5		29d. Dat	te signed (Monti		204
2			30 Name and address of person	who completed cau	ise of death (ftem 2	(Type, I	Print)		.) مدر			A=	حادث	15, 28	
D	B30		31. Date filed (Month, Day, Year	M(1).	12070	α	UNE	CE	NE	1	CLAC	1)414	t, Ma	206	200
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician Sherman Leon Scarboro 23:09 P M 17 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Prince Georges Clintan If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) Months 1☐M 2☐F 60 244-76-1244 Director 06/08/1945 N. Carolina Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at Yes 2□No Director MD PG Suitland 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? "natural", or items 23a 3009 Sunset Lane 20746 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Amed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Efementary/Secondary (0-12) Coflege (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: if Item 27 is marked other than any injury or other treumatic event, Imal ODG. 2 years Housekeeper Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Chester Scarboro Certha M. Barnes ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara L. Scarboro - Wife 3009 Sunset Lane; Suitland, MD 20746 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Nat'l Cemetery 10/25/2005 Laurel, Maryland 22. Name and Address of Facility Freeman Funeral Services 21. Signalure of Funeral Service Licens 6734 Hastings Drive; Capital Heights, Md 20743 blications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one-cause on each line. 23a. Part1. Enter the disease, or com shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ervivate disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (as a consequence Records, P.O. Box 68760. Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23d. Date of delivery 3 DEctopic pregnancy detached for Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 Probably 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate Division of Vital 1 ☐ Yes 2 🔀 No Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Pface of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitaf: 1 Yes 2 No ဥ 1 Inpatient 2 K ER/Outpatient 3 DOA After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification; 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 Yes 2 No within 24 hours after death. To the Funerel Director: A 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b Signature ar 29c. License number 29d. Date signed (Month, Dey, Year) 10-20-05 D0041580 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kelso, Scott A., M.D. 7503 Surratts Road Clinton, MD 20735 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar OCT 2 1 2005

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** October 1835 GAYLE LAVERNE SOCHOR 16, Jeris /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner cheverle Prince George's Hospital If Under 1 Year | MUnder 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours Months Days 1 □ M XXF 1948 57 APR. 26, VIRGÍNIA Director 577 04 4792 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County iral", or items 23a or 28a-f shov Examiner must be notified at XX Yes 2 □ No Director MARYLAND PRINCE GEORGES CAPITOL HEIGHTS 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? UNITED STATES 602 JADE LEAF AVENUE 20743 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 72 hours after Never Married 2 Married 1 ☐ Yes XX No Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: WHITE If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) traumetic event, the Medical 16b. Kind of Business/Industry Pages 1 and 2 should be filed within inent of Health and Mental Hygiene. Int: If Item 27 is merked other then " Elementary/Secondary (0-12) College (1-4or 5+) CAREGIVER PRIVATE 12TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be RUBY BRAGG MILTON S. SOCHOR, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 617 N. QUEEN ST. MARTINSBURG, WV 25401 DANNY RAY SOCHOR / BROTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XIX Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. WASHINGTON NATIONAL CEM. 10/24/05 4 Donation 5 Other (Specify) SUITLAND, MD 21. Signature of Cheral Service Licenses 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND_ROAD SUITLAND, MD 20746 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Closed Head Injuny **Physician** disease or condition resulting in death) /Medical 4 days Due to (or as a consequence of) **Examiner** elve tractive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Dis eminted Intravas certar Due to (or as a consequence of) P.O. Box 68760 attending physician Iclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 2 No director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred CAOSSING 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: Attanding street in undesignated 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☑ No October 12 2005 1200 2-Accident Diractor 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of 'njury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 0 24 hours a Funeral I 29a Certifier Medical the within To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 14050 SALVAdor Registrar's Signatur 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

OCT 2 1 2005

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ALMA HARRIS TANNER OCTOBER 2005 20 11:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1600 POSTAL ROAD CHESTER QUEEN ANNE'S 5. Social Security Number If Under 1 Months ear If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Min. Days Hours 1 ☐ M 2 🗶 F **Director** 215-20-2283 APR. 26. MD Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County itam 27 is marked othar than "natural", or items 23a or 28a-f show othar traumatic avant, the Modical Examinar must be notified at 1 ☐ Yes 2 XNo Director QUEEN ANNE'S CHESTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1600 POSTAL ROAD 21619 USA Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Amed Forces? 11. Marital Status Black, White, etc. ☐Yes 2 XNo Yes, Give 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHTTE þ 3 X Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7. Ih and Mental Hygiene. 7 is marked othar than "ni Flementary/Secondary (0-12) College (1-4or 5+) DATA INPUT SUPERVISOR INSURANCE 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be EDNA COLEMAN ပ ALFRED C. HARRIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If itam 27 is 1 211 WINELAND WAY, STEVENSVILLE, MD CRAIG A. COUNCILL/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State injury or permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE CEMETERY 10/25/2005 STEVENSVILLE, MD Arvice License 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK RD., CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Jonsmell Clll Priysician reacs /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Box 68760 certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) P.0 the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed 2 No Division of Vital Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 21 No 2 1 🗌 Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral dir this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation after death. М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier cai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month Day, Year) 29b. Signature nd title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZICIC DAVID H. SMITH, MD, 29466 PINTAIL DRIVE, SUITE 5, EASTON, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar OCT 2.5 2005

State of Maryland / Department of Health and Mental Hygiens 005 35921 = For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Groves Thompson October 19 2005 13:43 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Day, Year 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** 1□M 2XF 213-24-3474 79 Yrs 25, Director 1926 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Items 23s or 28e-f show the Medical Exeminar must be notified at Mα Montgomery Ashton 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20861 600 Ashton Road United States filed within 72 hours after death Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 □ Yes 2⊠No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White þ Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Federal Power Comm. 12 0 other other traumatic event, 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be 1 Department of Health and Mental I Importent: If item 27 Is marked o Dillion Groves Maude Frankhouser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20861 600 Ashton Road, Md. Judson C. Thompson / Husband Ashton, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Injury or Forest Oak Cemetery 10/22/05 Gaithersburg, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licensee murus P. O. Box 5038, Laytonsville, Ma. 20882 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition circhosis Physician months /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the attending physicien and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ wrosepsis 1 ☐ Yes No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed? 1 Yes 25 No Hospital or Attending Physician: 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 200 No 2 ER/Outpatient 3 DOA P 1 Tes 1 Inpatient this in by the tuneral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the e ţ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 2 licia J. Mistry MD D59738 October 21, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Alicia T. Mistry 9901 Medica center Drive Rockville, MD 20850 Medical 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 24 Registrar

		1 - State Registrar	State	of Marylan	d / Depa	artment or rtificate	of Heal	th and M	ental Hy	giere (•	35922
2. g		Decedent's Name (First, Middle	, Last)						2. Date of De	ath		3. Time of Death
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/Medic Examin		4a. Facility Name (If not institution	give street and no	umber)		4b. City, To	wn, or Loca	tion of Death	occobe.		nty of Death	10:00 -
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Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 '	Year If U	nder 24 Hrs. urs Min.	8. Date of Birt (Month, Da	h	ntgome 9. Birthp Cour	place (State or Foreign
Director		579-36-3814	1 □ M 2 🖫 F	77	Yrs.	, , , , , , , , , , , , , , , , , , ,	Jay 5	u13 ////////////////////////////////////	Feb. 2			* '
and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation					1	I Od. Inside City Limits
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3a or		1235 Potomac V	allev Roa	rđ		208				3, 5,11,21,1		,
filed within 72 hours after death with the Maryland Hygiene. The Hygiene sthen "natural", or items 23a or 28a-1 show ent, the Modified Examination neat be notified.	Funeral Director	11. Marital Status	12. Was Dec	cedent Ever in U.	.S. 13. \			c Origin? (Spe	cify Yes or No- Rican, etc.)	- 14. F	USA lace - Americ	
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lied v tygie thert		17. Father's Name (First, Middle, I		5+	Admin	nistra		Anthor's Namo	(First, Middle,			ernment
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d 2 s ith an 27 is trau		Morris Klein/				-			da, Mar			(2006)
permit. Pages 1 and 2 should be Dapartment of Health and Menta Important: If item 27 is marked any injury or other traumatic events.		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name	of		ate	20c. Locatio		own, State
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the a	ysic	1 □ Yes 2 No 9 □ Unknown	4∐Preg 9□ Unkr	nant at time of di nown	eath 5∟	Other (speci	<i>ty</i>)					
The law requires that the death certificate that been signed by the attending prage 2 should be detached for use as the		Part II. Other significant condition	ns contributing to	death but not resi	ulting in the ur	nderlying caus	e given in P	Part I.	23e. Did to	obacco use co	entribute to th	ne cause of death?
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Registr	-31	OCT 2 1	2005	MEURI A	J. A.							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician : 50AM 30 2005 Clara Mildred Wright /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner HEALTH AND BEL A REHAB BELAIR 8. Date of Birth (Month, Day,) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Maryland Hours Min 1 M 2 XF 82 1923 Yrs. 162-22-9548 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location r then "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Harford Bel Air MD 1 ☐ Yes 2 No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 410 E. MacPhail Road 21014 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: Completed by 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) at Hygiene. Elementary/Secondary (0-12) Coltege (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 1s marked othe any Injury or other traumatic event, 90ce. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Delmar Thomas Miller Anna Mary Norris ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary Jane Bennington/Dau. 1804 W. Fountain Green Rd., Bel Air, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State Slate Ridge Cem. 11/3/05 Delta, PA 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acuti Myocurell) minute **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): the th IF FEMALE: 23c. tf yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 2 Yes 2 No Day 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown À 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 3 Probably 4 □Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy ormed? 1 Yes Hospital of Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending death. investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital of Att within 24 hours after do To the Funeral Direct 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier

State
Registrar

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31. Date filed (Month, Day, Year)

North

32. Registrar's Signature

30. Name and address rerson who completed cause of death (Item 23a) (Type, Print)

D34652

Avenue Bil Air Mary) and 210/4

Cheryl Annette Williams Unknown Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05 05-07017 35924 1 - For State Registrar crn Reg. No. Certificate of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last 3. Time of Death Month Milliams Physician Chery Annet

4a. Facility Name (If not institution, give street and number) 15, 2005 3:35 P October /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner 8188 River Road Manokin Somerset If Under 1 Year II Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** ЦП Yrs. Months Days Hours Min 220-68-8952 1 ☐ M 2 🕱 F Director 08-01-1958 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10c. City. Town or Location 28a-f show other traumatic event, the Madical Examiner must be notified at MD 1 Yes 2 No Director OMERSE rincess 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 21853 28490 U.S. A Load or Items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (2x) es 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Black 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Madic 2006. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ampbell Jour Co. aborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Calvin FENNER Laudelle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phy DV. BERNARD White 36 Klinslow Catonuille MD 21228 20b. Place of Disposition (Name of cometery, crematory or other place)

Thus Comedities Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ■Burial 2 Cremation 3 Removal from State ST. Cemedley 10-22-05 4 ☐ Donation 5 ☐ Other (Specify) Vincess. 22. Name and Address of Facility
Anthony E. Ward Funeral Homo
30639 Humpden Ave Princess An 21. Signature of Funeral Service Licensee U 21853 MD -n ne, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Blunt force unjuries
Due to (or as a consequence of): **Physician** disease or condition resulting in death) Blunt /Medical Examiner Sequentially list conditions, Due to for as a consumence of dany leading to immedia cause. Enter Underlying Cause (Disease or injury attending physicien and I for use as the burial-transIt requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) signed by the at Id be detached fo 9□ Unknown 9/M Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 2 No 12 Yes 2 □ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 HOther (Specify) at Scene 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospitat or Attending Phys within 24 hours after death. To the Funeral Director: Atter this completely filled in by the funeral di this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 3.23 PM 1 Natural 5 Pending 1 ☐ Yes 2 🗖 No investigation Subject assouted 2 Accident OC+ 15, 2005 6 Could not be 3 ☐ Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide determined 8188 River Road Manokin formal in woods 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MID O.C.M.E. 7000

State Registrar

31. Date liled (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tasha Z Greenberg M.D

October 16, 2005

111 Penn Street, Baltimore, Maryland 21201

32. Registrar's Signature Elem & Speck

			1 - For State Registrar	State of Man		artment of H		Re	g. No.	35925
	Physici /Medi		Decedent's Name (First, Middle, Last) Warren Wende	ell Weil	.Sr.			2. Date of Death Month	Day Year 71 2005	3. Time of Death 7 46 p M
	Examir		4a. Facility Name (If not institution, give s Peninsula Regional	, ,	Centu	4b. City, Town, or	Location of Death		4c. County of Deat	
	Funeral Director	X**	5. Social Security Number 6. Sex		n yrs. last birthday) 5 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct. 20,		hplace (State or Foreign untry)
	aryland show dist	L.	Usual Residence of Decedent 10a. State 10b. County Md. Wicomico	10	Oc. City, Town or Lo					10d. Inside City Limits 1 ▼Yes 2 □ No
	ith the Ma or 28a-f	Director	10e. Street and Number		Salisbui	10f. Zip Code		10	og. Citizen of What Co	11
	ath w	rail	903 Friar Tuck 1		-1-110	21804			USA	
336	72 hours after death with the Maryland natural', or Items 23s or 28s-1 ehow dical Exeminat must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Novorced	 Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 	1	was Decedent of H if Yes, specify Cuba 1 ☐ Yes 2☐XNo	ispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	14. Race - Ame Black, White Specify: Africa	
21215-0036	C * 100	Completed by	15. Decedent's Educ (Specify only highest grade	ation completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done o OO NOT use retired	ation during most of work f)	ang	16b. Kind of Business/	Industry
	2 should be filed within and Mental Hygiene. Is marked other then aumetic event, the M	e Con	12 17. Father's Name (First, Middle, Last)	2	Elec	trician	18. Mother's Nam	e (First, Middle, N	<u>-</u>	t Contractor
Maryland	ould be Mental Marked o	To B	Julius	Weil			Marg			eil
	and 2 sho ealth and n 27 is mu		19a. Informant's Name/Relationship (Type Terri Weil /	oe, Print) Daughter	19b. Mailir 903	•			City or Town, State, 2 y , $Md.21804$	Tip Co de)
Baltimore,	Pages 1 and 2 nent of Health int: If item 27 I	_	20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Re		20b. Place of Dispo cemetery, crer	esition (Name of matory or other place	(e)		20c. Location - City or	
altim	i and and	«'	4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service License						Dover,De th Funeral	
8	P G E	\	Pent Filer le disease, or o meli	100						1801 Approximate
,8760,	Physician / Medical physician and physician and physician and physician and the phys	dical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Der	al 1	ailure				
.O. Box 6	The law requires that the death certific te has been signed by the attending poored is should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 2	Fetaf death 3		020.000		23d. Date of del Month	ivery Day Year
9	quires that n signed by uld be deta	þ	Part II. Other significant conditions con	tributing to death but r	not resulting in the u	nderlying cause giv	en in Part I.		eacco use contribute to	٤ ۵
Records,	Physician: The law requir this certificate has been si rat director, page 2 should t	Completed			20b. Place of Disposition (Name of cemetery, crematory or other place) 10/24	24a. Was ar autops perform 1 Yes 2	y prior to death?	itopsy findings available completion of cause of		
Vital	cian: ertifica	Be	25. Was case referred to medical examiner?			l ou		th Check only one	9)	
of\	Physician: this certific ral director,	2	1 ☐ Yes 2 No	ospital: 1 Impatient 28a. Date of Injury		II JU DOA	4 Li Nursing no	ome 5 Reside	nce 6 Other (Spe	cify)
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Divi	al or Att	Sertiff	3 Suicide 6 Could not be 4 Homicide determined	28e. Pface of Injury building, etc. (- At home, farm, sti Specify)	reet, factory, office		28f. Location (Str City or Town	reet and Number or Ru , State)	iral Route Number,
	To the Hospital or Attending i within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C		er: On the basis of ex	ramination and/or in	vestigation, in my o	pinion, death occur	red at the time, da	ate and place, and due	
	To th withir To th comp	Me	29b. Signature and title of certifier	-	700	29c. Licens	e number	29	9d. Date signed (Mont.	h, Day, Year)
			30. Name and address of person who co	months of Jean	th (ftem 23a) (Type,	Print)	C / 1		1) 2.6	,
	St Regist	ate rar	31. Date filed (Month, Day, Year) OCT 2 4 20	32. Registrar's	in (ftem 23a) (Type, 20 E. Ca. Signature	parker	-20/15 C	ury, m	D. 0(80)	/

Warren Weil 38-38-5539

				For State Registrar	State of Maryland	Department Certificate		Mental Hygien Reg. i	000	35926
	2	Physici /Medic		1. Decedent's Name (First, Middle, Las	Whit	e J	Γ,	October	ay 1 200	
		Examir Funeral	er	4a. Facility Name (If not institution, give PENIN SULA SULA SULA) 5. Social Security Number 6. Sulain Sula	1 Medical Cen	birthday) If Under 1		8. Date of Birth	4c. County of Dea	thplace (State or Foreign
	250 A	Director		218-41-5404 1.	9(M 2□F 61	Yrs. Months	Days Hours Min.	(Month, Day, Yea	is co	mD.
		e Maryland	ctor	10a. State 10b. County Wicon	10c. City, To	own or Location				10d. Inside City Limits 1 PYes 2 □ No
		ath with the Maryla 23a or 28s-f shor	ai Director	10e. Street and Number 609 Kelving	ton Avenue	10f. Z ip 0	1201	10g.	Citizen of What Co	ountry?
	36	or items	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Properties	12. Was Decedent Ever in U.S. Armed Forces? 1 RYes 2 No 1962 If Yes, Give	1 ☐ Yes 2	int of Hispanic Origin? (Sp iy Cuban, Mexican, Puerto No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
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ty.	1d 2121	be filed within 72 h ital Hygiene. id other than "natu event, Ire Mudical	Be Comp	17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Chef		ne (First, Middle, Maid	on Sumame)	7 Village
3	Maryland	should nd Mer marke umatic	ToB	Orville Rub 19a. Informant's Name/Relationship (1)	IED White	9b. Mailing Address (Kath Street and Number or Ru	Reco R. Route Number, City	hock y or Town, State,	Zip Code)
11/6		1 an Heali em 2 ther	1	Terry Johnso 20a. Method of/Disposition 12 Burial 2 □ Cremation 3 □	come	of Disposition (Name atery, crematory or oth	er place)		Location - City or	
ORUIL	Baltimore,	permit. Pages Department of I Important: If its any injury or o		4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen	y) Gree	22. Name and	Cen. 10-2 Address of Facility Smith for Fabella 5+	9-05 Sa	lis bury,	nd. 2189
		705 # 0		23a. Part1. Enter the disease, or compshock, or heart failure. List only		o not enter the mode	or dying, such as cardiac	or respiratory arrest,	lisbury	Approximate Interval Between Onset and Death
	135	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence	ce of):	tha	•		Hvs
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	68760,	icate be executed physician and s the burial-transit	cai Examin	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequence d	50 p 5 v	7			Wers
	Вох	ath certif attending for use as	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	ath 3 Ectopic pre			23d. Date of de Month	livery Day Year
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	Division of Vital Records,	The law requite has been sage 2 should	Completed		peri plem	Variala	ye Disy	24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
	/ital	cian: ertifica ector, p	Bec	25. Was case referred to medical examiner?	UA-LN C			th (Check only one)	40 12 163	2010
	of	Physi or this o	. To	1 ☐ Yes 2 XNo 27. Majener of Death		Outpatient 3 DOA b. Time of 28	Other: 4 Nursing He c. Injury at Work?	ome 5 Residence		cify)
	vision	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	n	М	1 ☐ Yes 2 ☐ No	28f. Location (Street		ural Route Number,
	Ö	spital or hours afte ineral Dir y filled in	1 -	29a. Certifier 1 Certifying Ph	ysician: To the best of my knowled	dge, death occurred at	the time, date and place,	City or Town, Sta	(s) and manner as	s stated.
		the Ho	Medical	one)	niner: On the basis of examination and manner stated.		n my opinion, death occur License number			
4		7. 00		29b. Signature and title of certifier	WID		2/6725	290. [Date signed (Mont	1
C	1. 1	i,	. 3	30. Name and address of person who a	completed cause of death (Item 23	a) (Type, Print)	show MD			,
0	3,	Sta		31. Date filed (Month, Day, Year) OCT 2 5 2						

			For State Registrar	State of Ma	arylan	id / Depa <i>Cer</i>	irtment of H tificate of I	lealth and Death	l Mental I	Hygier Reg. i		35	927
1			1. Decedent's Name (First, Middle, Li	ast)					2. Date of Month	Death	Day Yes		ime of Death
77	Physici /Medic		JOSEPH FRANCIS	JEBER JR.					OCTO		22 200		1:55P M
40	Examin	er	4a. Facility Name (If not institution, gi				4b. City, Town, or		ath		4c. County of D		
10.0		Section.	7015 ORCHARD VI 5. Social Security Number 6.		a (In vrs	last birthday)	HUGHES	/ LLLE If Under 24 H	rs. 8. Date of	Birth	CHARLI		State or Foreign
4	Funeral Director	1		1⊠M 2□F		2 Yrs.	Months Days	Hours Mi		Day, Yea	933 PI	Country) ENNSYL	State or Foreign
	D	9	Usual Residence of Decedent						JODI				
	ehow	ř	10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						side City Limits ∃Yes 2 🙀 No
	28e-f	Director	MD CHARLES 10e. Street and Number		HUG	HESVIL	LE 10f. Zip Code			100	Citizen of What		
	with Ba or		7015 ORCHARD VI	EW LANE			20637			, og.	U. S. A		
	death me 2:	Funerai	11. Marital Status	12. Was Decedent I	Ever in U	.S. 13. \	Vas Decedent of H	ispanic Origin?	(Specify Yes or	No-	14. Race - A	mencan Ind	ian,
36	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other then "natural", or Iteme 23a or 28e-f ehow aumatic event, the Medical Example armatic event, the Medical Example and the codified at	by Fur	1 ☐ Never Married 2 ★ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1;∑XYes 2 □ N If Yes, Give Year or Dates:	40		Yes 2½ No	Specify:	впо нісап, віс.)	Specify:	/hite, etc. VHITE	
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anc	Mental H arked of atic ever	Be c	JOSEPH F. WEBER						RYN ZUBI		en Sumame)		
Maryland	ss 1 and 2 should of Health and Men Item 27 Is marke other traumatic	2	19a. Informant's Name/Relationship			19b. Mailin	g Address (Street				y or Town, Stat	e, Zip Code,	
	and 2 Balth a m 27 is		LAURA J. WEBER	/ WIFE		7015	ORCHARD V	IEW LAN	NE HUGHI	ESVIL	LE. MO	20637	
altimore,			20a. Method of Disposition	Dames of from State	20b. F	Place of Dispo	sition (Name of natory or other place		Date OBER		Location - City		ate
Ĕ	Pages nent of ent: If It ury or o		12 □ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		l	VETERA	NS CEMETI	ERY 27	2005	CH	ARLOTTE	HALL	. MD
Balt	permit. Page Depertment Importent: If any injury or once.		21. Signature of Funeral Service Lice	insee	MOO	1641 30	. Name and Addres	ss of FacilityBI	RINSFIE	LD-EC	HOLS FL	JNL.HM	E.,P.A.
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused	the deat							Appro	oximate
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. <u>CHRONIC</u> Due to (or as	REN		LURE						
84	Examiner		Cognostially list conditions	September 1990 and 1990 and 1990 and 1990 and 1990 and 1990 and 1990 and 1990 and 1990 and 1990 and 1990 and 19		Commence Commence and	VASCULA	DISEAS	SE			Approximate Interval Between Onset and Death SIX MONTHS	
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	and and I-trans	xam	that initiated events resulting in death) Last	c. HYPERTE Due to (or as								MANY	YEARS
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Box	The law requires that the death certifics ate hes been signed by the attending pt page 2 should be detached for use es it.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Feta	il death 3 ☐	Ectopic pregnancy Other (specify)				23d. Date of Month	delivery Day	Year
о. О	it the de by the a tached	hysi	9 Unknown	9□ Unknown									
Division of Vital Records, F	uires that signed to ld be det	by	Part II. Other significant conditions DEPRESSION	contributing to death be	ut not res	ulting in the u	nderlying cause giv	en in Part I.			o use contribut		
S	w requir been si should	Completed	HYDROCEPHALUS						24a. V	Vas an	24b. Were	autopsy fin	dings available
Re	The lav	ошо								utopsy erformed s 2000	? death	to completion? res 2 🗆 N	dings available on of cause of
a	icien: Th certificate rector, pag	a	25. Was case referred to medical					26. Place of D	eath (Check of		NO TO	65 2 1	-
>	Physicien: r this certifica ral director, i	To B	examiner? 1 ☐ Yes — 2 X ONo	Hospital: 1 Inpatie	nt 2	ER/Outpatien	t 3 DOA Oth	er: 4 Nursing	Home 5 🗓 F	Residence	6 Other (S	ipecify)	
0	iding Physicien: th. : Atter this certifica i funeral director, p		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju	ry y Year)	28b. Time of Injury	28c. Injur Wor		28d. Descr	be how in	jury occurred		
Sio	r Attending ter death. Irector: After by the fune	icati	2 Accident investigate 3 Suicide 6 Could not	he	At h	omo form etc		Yes 2 ☐ No	29f Leastin	- (Ctroot	and Mumber of	Direct David	Alimbar
$\overline{\mathbf{z}}$		Certification;	4 ☐ Homicide determine	d building, etc	c. (Specil	(y)	eet, factory, office		City or	Town, St	and Number or ate)	HUFA) HOUR	e Number,
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	Medical C	29a. Certifier (Check only one) XX Certifying F	Physician: To the best of aminer: On the basis of and manner sta	examina	owledge, death ation and/or in	occurred at the ting restigation, in my o	ne, date and pla pinion, death oc	ice, and due to curred at the ti	the cause	(s) and manner and place, and	as stated.	ause(s)
	To the I within 2 To the I complet	Me	29b. Signature and title of certifier		17	7	29c. Licens	e number		29d. (Date signed (M	onth, Day, Y	(ear)
)				フ・レ・レ			D21	173		00	TOBER 2	24. 20	05
1	V rec l		30. Name and address of person who	•			•						- •
1	וזטת		NIRAN SHARMA, M. 31. Date filed (Month, Day, Year)	D. 3460			NGTON ROA	D SUITE	103A W	ALDO	RF, MAR	YLAND	
	Sta Registr		OCT 2.4			H A	racks						

Amended Item 5 per F.D. 10/25/2005 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygierne 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 12-47AM WESLEY JOHN 2005 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CARROLL CARROLL HOSPITAL CENTER WESTMINSTER If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 528P#<u>31-3760rit</u>89311791 8. Date of Birth 9. Birthplace (State or Foreign Funeral Nov. 22, 1919 Days Hours Min 1 ☑ M 2 ☐ F 85 Maryland Yrs. Director 36 8317 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Carroll New Windsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2441 Marston Rd. 21776 U.S.A. or Itema 23a Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any injury or other traumatic event, the Medicul Exercities. Once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 Nidowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) farmer agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be David Wilt Pearlie Franklin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan W. Hoff/daughter 2441 Marston Rd. New Windsor, MD 21776 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 10/29/2005 | nr. New Windsor, MD Winters Cemetery ⁴ □ Donation 5 □ Other (Specify) 21. Sign of Fureral Service Licer 22. Name and Address of Facility Hartzler Funeral Home atharine 310 Church St. New Windsor, MD 21776 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CEREBRO VASCULAR ACCI DENT Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner HEART CONGESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed CHRONIC ATRIAL FIBRILLATION Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 4 Pregnant at time of death 5 ☐ Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 Tyes 2 k No 3 Probably 4 DUnknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 28 No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death [Check only one] Hospital: 1 Inpatient Other: ို 1 Tyes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; Injury 1 🖪 Natural 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide 29a. Certifier 1 🕏 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0058580 10/22 10emu 2009 WJL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Kanu. 3233 Suffector LN, 821. BONIE, 32. Registar's Signature State Elmen & Spark 2005 Registrar

		1 - For State Registrar	State of Mary		irtment of He tificate of D		Mental Hy	giệne 05	35930
		Decedent's Name (First, Middle, Las	it)				2. Date of De	eath	3. Time of Death
Physic /Medi		Ro	nald Dougla	s Widdoes	3		Octobe	Day Ye	a market A M
Exami		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Deat		4c. County of D	Peath
		Union Hospital			E1kton			Cecil	
Funeral		5. Social Security Number 6. S	MM 3DE	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Da	rth ay, Yeer) 9.	Birthplace (State or Foreign Country)
Director		212-70-2396 Usual Residence of Decedent	49				July 19	9, 1956	Maryland
nyland how		10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits
89-1 s	cto	Maryland Cecil		E1kton					1 ☐ Yes 2 🏋 No
with the	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of What	•
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of the right	Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No		Vas Decedent of His Yes, specify Cubar		to Rican, etc.)	Black, V	/hite, etc.
ours a	i by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2 No	Specify:		Specify:	White
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Eventres must be notified at any once.	Completed by Funeral Director	15. Decedent's Ed (Specify only highest gra		(Give	ent's Usual Occupa	uring most of wo	rking	16b. Kind of Busine Automobi	
withir	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		oo not use retired) e/Security		isor	Manufact	
C 2 Filed Hyginal Sther	Ö	17. Father's Name (First, Middle, Last)						, Maiden Sumame)	
Maryland d 2 should be file th and Mental Hy t7 is marked oth traumatic event	To Be	Charles Ronald W	liddoes			Mildre	d Galyer	n	
ary		19a. Informant's Name/Relationship (7	Гуре, Print)	19b. Mailin	g Address (Street a	nd Number or Ru	ural Route Numb	er, City or Town, Stat	e, Zip Code)
and and and and and and and and and and		Deborah E. Widdo						Maryland 2	
Ores 1 tof H itel		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	Ob. Place of Dispo: cemetery, cren	sition (Name of natory or other place		ber 31,	20c. Location - City	
Baltimore, permit. Pages 1 at Department of Hea Important: If item any injury or other once.		' 4 ☐ Donation 5 ☐ Other (Specify)	Sharps C		20			, Maryland
Bal permi Depa Impo any ir		21. Signature of Funeral Service Licen	See	Ні	Name and Address	for Fun	erals, l	P.A.	1 1 01 001
		23a. Part1. Enter the disease, or comp	olications that caused the						y1and 21921 Approximate
Pnysician		shock, or heert failure. List only immediate Cause (Final	R	1.	1 1879-01				Interval Between Onset and Death
/Medical	ı	disease or condition resulting in death)	a Due to (or as a co		inch				3 months
Examiner	١.	Sequentially list conditions	b						
Sit 80	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Jissans or Injury)	Due to (or as a co	nsequence of):					
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68 tifficati	Medicai								
Box death certification of for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		Ectopic pregnancy			23d. Date of	
O. E. e. dea	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time 9☐ Unknown		Other (specify)			Month	Day Year
I Records, P.O. Box (The law requires that the death certif ste has been signed by the attending page 2 should be detached for use a	Phy	Part II. Other significant conditions or	ontributing to death but no	ot resulting in the un	iderlying cause give	n in Part I	23e Did 1	tohacco use contribut	e to the cause of death?
Division of Vital Records, P or Attending Physicien: The law requires that after death. Director: After this certificate has been signed to the tuneral director, page 2 should be det	d by				donying oddao givo	THE CALL I.	1 🗆		Probably 4 Unknown
w requ	Completed					-	24a. Was		autopsy findings available
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ital	a)	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes	20X No 1 🗆 1	fes 2□No
of V	To B	examiner? 1 ☐ Yes 2 🗖 No	Hospital: 1 Inpatient	2 ER/Outpatien	0.4-			dence 6 Other (S	Specify)
In O Pi		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. Time of Injury	28c. Injury Work		28d. Describe	how injury occurred	
ISIO	icati	2 Accident investigation 3 Suicide 6 Could not be		At home form at a		es 2 No	OOL Leasting (Channel and Mumber	Out of Courts All states
Div after Direction by	Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (S		eet, ractory, office		City or To		Rural Route Number,
Division of Vital Rec to the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Ph	ysician: To the best of m	y knowledge, death	occurred at the time	e, date and place	, and due to the	cause(s) and manner	r as stated.
he Ho n 24 l he Fu pletely	edicai	(Check only 2 Medical Examone)	niner: On the basis of exa and manner stated.	mination and/or inv	estigation, in my op	inion, death occu	irred at the time,	date and place, and	due to the cause(s)
To the I within 2 To the I complet	Σ	29b. Signature and title of certifier			29c. License	number		29d. Date signed (M	
/)		1H. Jacka	1 MD		D15	714		October 2	7,2005
8		30. Name and address of person who	completed cause of death	(Item 23a) (Type, I	Print)	0 11	,- 11.	h	2
V C1	ate	31. Date filed (Month, Day, Year)	32. Registrar's	1 1/05/17 Signature	al, 106	Bo U 51.	, 6 /K/	on, MD	41921
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			For State of Marylar		artment of He tificate of D		ental Hygi Re	005	35931		
			1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death		
	Physicia /Medic		Mary Rebecca Wiggins				October 0	28 2005	1830 P M		
7	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or I	Location of Death		4c. County of Death			
			202 Skipjack Circle		Elkton			Cecil			
	Funeral		1□M 2IVE	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 10 OCT 11,	Year) 9. Birthp	lace (State or Foreign		
	Director	}	220-26-1674 1 M 2 A F 78 Usual Residence of Decedent	113.			0CT 11,	1927 Mar	yland		
	land			ity, Town or Lo	cation			1	0d. Inside City Limits		
	Mary -f eh	ğ	Maryland Cecil	E1kton					1 X Yes 2 No		
	r 28a	Director	10e. Street and Number	DIREON	10f. Zip Code		10	g. Citizen of What Cour	ntry?		
	h with		202 Skipjack Circle		21921			United Sta	ites		
	deat	Funeral	11. Marital Status 12. Was Decedent Ever in U	J.S. 13. V	Vas Decedent of His Yes, specify Cuban	panic Origin? (Spe	cify Yes or No-	14. Race - Americ Black, White,			
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Thomas Luther Short Specific properties 1							White				
<u>7</u>	"nat	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Waitress						6b. Kind of Business/Ind	dustry		
2	withir	m d	Elementary/Secondary (0-12) College (1-4or 5+)		tress			Restauran	t		
р Б	filed Hygi sther	e Co	17. Father's Name (First, Middle, Last)	1141		18. Mother's Name	(First, Middle, M.				
au	ld be lental kad c	To Be	Thomas Luther Short			Bessie	e Lee Wi	1kerson			
ary	shou and M a mar umat	 	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street a			City or Town, State, Zip	Code)		
Ž	and 2 alth a 127 le		John W. Insley, Sr./Son	101 N	orth Tart		E1kton	, Maryland	21921		
ore	es 1 and He of He richter		20a. Method of Disposition 20b. 1 ☐ Burial 2 ፟X Cremation 3 ☐ Removal from State	Place of Dispo cemetery, cren	sition (Name of natory or other place	Octob	er k	Oc. Location - City or To Vest Cheste:	wn, State		
altimore,	Pag ment ant: I ury o			A. Ferris	& Co. Inc.	31, 2	2005 I	Pennsylvani	a		
Balt	permit. Departi Import any inj		21. Signature of Funeral Service Licensee	H 1	Name and Address icks Home 03 W. Stor	for Fune	rals, P.	A. kton, Maryl	and 21921		
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Вох	h cert endin use	M/UR	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fet		Ectopic pregnancy			23d. Date of delive	*		
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	The ta te has age 2	Completed					autopsy perform	ed2 prior to condeath?	mpletion of cause of 2□ No		
ita		BeC	25. Was case referred to medical			26. Place of Death					
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0	es that the death certificate be executed to the state of the strength of the state of the strength of the state of the strength of the state of the strength of the state of the strength of the strength of the state of the strength of the		27. Manner of Death 1 Natural 5 □ Pending (Month, Day Year)	28b. Time of Injury	Wark'		8d. Describe hov	v injury occurred			
sio	tendi Jeath tor: A	cati	2 Accident investigation 3 Suicide 6 Could not be			es 2□No	196 Location /Ctm	ant and Number of Dura	I Pauta Number		
<u>></u>	s after or Al	Certification;	4 Homicide determined 28e. Place of Injury · At I building, etc. (Spec	nome, rarm, str hify)	еет, тастогу, оптсе	-	City or Town,	eet and Number or Rura State)	i noute Number,		
	Hospit 24 hour Funera etely fille	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kn and manner stated.								
	To the within To the compl	Me	29b. Signature and title of certifier		29c. License			d. Date signed (Month,	Day, Year)		
•	0		Morrom			60756					
	7		30. Name and address of person in Impleted cause of death (Ite	em 23a) (Type,	Print)	wn	nain S	H.Elkb	n, MD.		
	Sta Registi		31. Date filed (Month, Day, Year) 2. Registrar's Sign	nature	W						

			For Stete Registrar	State of I	Maryland / [t of H	ealth a	nd Mental I	lygiene (•	35932		
	Physici		1. Decedent's Name (First, Middle		yvill				2. Date of Month	Death Day	Year	3. Time of Death		
			4a. Facility Name (If not institution MENCYMEN)			4b. City,	1	Location of	Death	4c. C				
	Funeral Director		5. Social Security Number 579-48-7093	6. Sex 7. 1 X M 2 □ F	Age (In yrs. last bir 71	rthday) If Under Yrs. Months		If Under 2 Hours	4 Hrs. 8. Date of	Birth Day, Year) 25, 193	9. Bin Cc Wa	thplace (State or Foreign buntry) ashington, D		
	th the Maryland or 28e-f ehow	irector	Usual Residence of Decedent 10a. State 10b. County	ce George's	George's Adelphi					1 🗆 Y e				
	23a c	alD	10415 Rutland	Place			20783	3		U	SA			
980	ours after des rel', or Items Examiner m	by Funer	11. Marital Status 1 □ Never Married 2 ☑ Mar 3 □ Widowed 4 □ Divorced	If Yes Give	s? ∑ No	13. Was Deced If Yes, spec			in? (Specify Yes or Puerto Rican, etc.)		Black, Whit	e, etc.		
21215-0	aw requires that the death certificate be executed as signed by the attending physician and a signed by Physician/Medical Examiner Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28e-1 ehow any njury or other treumetic event, the Medical Examiner must be notified at any njury or other treumetic event, the Medical Examiner must be notified at any njury or other treumetic event, the Medical Examiner must be notified at any njury or other treumetic event, the Medical Examiner must be notified at any njury or other treumetic event, the Medical Examiner must be notified at any njury or other treumetic event, the Medical Examiner must be notified at any njury or other treumetic event, the Medical Examiner must be notified at any njury or other treumetic event, the Medical Examiner must be notified at a property or the attendance of th	mpleted	15. Deceder (Specify only highe Elementary/Secondary (0-12)	nt's Education st grade completed) College (1-4c	or 5+)	Decedent's Usua (Give kind of wo life. DO NOT us	rk done di se retired)	u <i>ring</i> most (
302	illed Hygi other	Č e	17. Father's Name (First, Middle,		110	amp Agen						ing		
/lar	Venta	To B	John Christoph	er Wyvill,	Sr.			Ruth	Mildred	Mayhew				
dar)	2 sho and I is me	·	19a. Informant's Name/Relations	ship (Type, Print)	19b	. Mailing Address	(Street a	nd Number	or Rural Route Nu	mber, City or	Town, State, 2	Zip Code)		
	. Pages 1 and Iment of Health tent: If item 27 jury or other the		Barbara L. Wy: 20a. Method of Disposition 1☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 □Removal from Sta	20b. Place of cerneter	1415 Bit Disposition (Namery, crematory or of Heaven Co	ne of ther place) 0	Date	e of Death Day Year J2: 07 P M 4c. County of Death Accounty of Marshall of Death Accounty of Marshall of Death Accounty of Marshall of Death Accounty of Marshall of Death Accounty of Marshall of Death Accounty of Marshall of Death Accounty of Marshall of Death Accounty of Marshall of Death Accounty of Marshall of Death Accounty of Marshall of Death Accounty of Marshall of Death Accounty of Marshall of Death Accounty of Marshall of Death Accounty of Marshall of Death Accounty of Marshall of Death Accounty of Marshall of Death Accounty of				
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Į.			23a. Fart. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	ai ~ T	sed the death. Do not have a CRAM as a consequence	ine U	e of dying	such as ca	ardiac or respirator	y arrest,		Interval Between		
8760,		icai	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. LEF	as a consequence of	y UYN	apek	MA				year Year Year Year Year Year Year Year Year Year Year 12,076 M Yof Death Year 9. Birthplace (State or Foreign Country) Washington, De 10d. Inside City Limits 1		
Box 6	the death certifics y the attending pf iched for use as t	ysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death at time of death	3 □Ectopic pr. 5 □ Other (sp.				23				
	quires that n signed b ıld be deta	by	Part II. Other significant conditions of the state of the	ons contributing to death M としいい	but not resulting in	the underlying ca	ause giver	n in Part I.						
000	aw red	piete	- HYSERTEN	Siew							24b. Were au	topsy findings available		
tal Re	hysicien: The k nis certificate ha I director, page 2	0	- COPONAMY 25. Was case referred to medica	11.010.	11384	138-		26 Place o		rformed? s 25 No	death?			
Division of Vital	ing P	ation: To B	examiner? 1 Yes 2 No 27. Manner of Death Danatural 5 Pendin 2 Accident investignment	28a. ate of Ir (Month, I			8c. Injury : Work?	4 Nurs	ing Home 5 Re 28d. Describ	sidence 6		sify)		
Divis	el or Attencs after death	27. Manner of Death Natural 5 Pending investigation Suicide 4 Homicide 4 Homicide 288. Tate of Injury (Month, Day Year) 288. Tate of Injury (Month, Day Year) 288. Time of larger (Month, Day Year) M 288. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)												
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical (stated. to the cause(s)		
	To t To t comp	Σ	29b. Signature and title of certifie	_			License			29d. Date s	signed (Month	Day, Year)		
-	HOTI		PLSDAT			D	47	934		GUPOBL	N 11	2005		
3	The second		10000.(111	5 MD . 3				BAUT	mont 1	40 2	120			
1000	Sta Registr	36	31. Date filed (Month, Day, Year)	1 2005 32. Wgis	strar's Signature	Sperte								

			1- State of Maryland / Department of Health and Certificate of Death		giene Reg. No. 005 35933
	D.		1. Decedent's Name (First, Middle, Last)	2. Date of De	of third of Boatif
	Physici /Medic		MARY WEITZBERG	Octobe	r 19, 2005 1:45 P M
)*	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of De	eath	4c. County of Death
			1801 East Jefferson St #118 Rockville		Montgomery
	Funeral			lin. (Month, Da	y, Year) Country
	Director		130-28-4104	May 4,	1910 Brooklyn, NY
	and		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	Mary -fsh	ţo	MD Montgomery Rockville		1 ☐ Yes 2 🙀 No
	r 28a	Director	10e. Street and Number 10f. Zip Code	-	10g. Citizen of What Country?
	h with		1801 East Jefferson Street #118 20852		United States
	deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	(Specify Yes or No	- 14. Race - American Indian,
ထ္	after or Its		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, specify Cuban, Mexican, Pu	ierio Hican, etc.)	Black, White, etc.
8	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show ha Madical Examiner must be notified at	d by	3 ₩ Widowed 4 Divorced Year or Dates:		Specify: White
<u>.</u>	"nat	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of a	working	16b. Kind of Business/Industry
12	withir ane. than	dm	Elementary/Secondary (0-12) College (1-4or 5+)		_
р 2	Hygie ther		2 Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	Name (First, Middle,	Insurance
an	d be ental cad o	To Be		ria Brenn	maddi damandi
ar.	shound Mind Mind Mind Mind	-	19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and Number or</i>		ar, City or Town, State, Zip Code)
Ž	alth a 27 is		Vicki Mechner, Daughter 9690 Farmside Place,		
Baltimore, Maryland 21215-0036	parmit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place)	Date	20c. Location - City or Town, State
Ĕ	Page Int: If		X Buriai 2 Cremation 3 Memoval from State	-21-2005	Olney, MD
a	parmit. Departnimporta				aldi Funeral Home Inc
<u>m</u>	4 9 E 8 9				lver Spring MD 20904
e	5		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.	fiac or respiratory ar	Interval Between
5	Physician		Immediate Cause (Final disease or condition Pancreatic Cancer		Onset and Death 1 Year
	/Medical Examiner		resulting in death) Due to (or as a consequence of):		
П	Lammer	_	Sequentially list conditions, b.		
	ed sit	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury		
	and al-trar	xan	that initiated events c		
8760,	The law requires that the death certificate be executed ite has been signed by the attending physician and rage 2 should be detached for use as the burial-transit	dical E			
687	ificate g phy: as the		d		
Вох	leath certific attending p	Z	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery
	deatl e atte	icla	in the past 12 months? 1 Yes 2 No 1 Yes 2 No 1 Other (specify)		Month Day Year
P.0	that the de led by the a detachad t	hys	9 Unknown		
	res tha igned be del	by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to the cause of death?
ord	w requir been si should I	ted		1 U Y	'es 2 kNo 3 Probably 4 Unknown
Records,	e law r has be je 2 sh	Completed		24a. Was a autop	
		Col		perfor 1 ☐ Yes	med? death?
Viital	ysician: The is certificate director, pag	Be	GABITIS (9)	eath Check onl or	ne
	A S P	2			ence 6 Other (Specify)
L _O	ding h. After fune	lo l	1 Natural 5 Pending (Month, Day Year) Injury Work?	28a. Describe n	ow injury occurred
Division of	or Attending Phater death. Director: After thin by the funeral	fica	3 Suicide 6 Could not be 28e. Place of Injury - At home farm street factory office	28f. Location (S	Treet and Number or Rural Route Number,
2	5 5 5 6	Certification:	4 Homicide determined building, etc. (Specify)	City or Tow	n, State)
	To the Hospital or within 24 hours after to the Funeral Dir completely filled in I	aC	29a. Certifier 125 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pla	ice, and due to the o	cause(s) and manner as stated.
	n 24 he Fu	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death oc and manner stated.	ccurred at the time, o	date and place, and due to the cause(s)
	To t To t Com	Σ	29b. Signature and title of certifier 29c. License number	2	29d. Date signed (Month, Day, Year)
	10		Clan Clarestote a) D009745	(October 19, 2005
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		
			Alan Weinstock, M.D. 10313 Georgia Avenue Suite 105,	Silver Sp	pring, MD 20902
	Sta Registr	_	31. Date filed (Month, Day, Year) 32. Degistrar's Signature		
	riegisti	-10	OC 1 & T 5003		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 5 per fh 9850 12-6-05 vt.

State of Maryland 7 Department of Health and Mental Hygiene

1 - For State Registrar Reg. 40.U U Certificate of Death L Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 8:12P M WARREN P. STEWART OCTOBER 2005 18, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3500 OLD SILVER HILL ROAD PRINCE GEORGES SUITLAND If Under 1 Year | If Under 24 Hrs. 5. Social Security Number **2532** 216 22 2552 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours XX M 2□F Months Days Yrs. Director JAN. 14, 1926 MARYLAND Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show traumatic evant, the Medical Evaninar nust be nutified at XX Yes 2 No Director 28e-f DC WASHINGTON 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? with ö or itams 23a 20002 615 F STREET, NORTHEAST UNITED STATES Funerai 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? XX Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes XX No 2 Specify Specify: BLACK XX Widowed 4 □ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 12 should be filed within 72 h and Mental Hygiene. 7 is markad other than "na Elementary/Secondary (0-12) College (1-4or 5+) 12TH CLERK DEPARTMENT OF AIR FORCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOSEPH R. STEWART FLORENCE WARREN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s if Health an itam 27 is Ar Pages 1 & Jepan 1 & Jepan 2 & Jepan 2 & Jepan 3 & Jep FLORENCE ECTOR / SISTER 3500 OLD SILVER HILL RD. SUITLAND, MD 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State tXBurial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) LINCOLN MEMORIAL CEM. 10/24/2005 SUITLAND, MD 21. Signature of Funeral Service Ligensee MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Sause (Final Physician disease or condition resulting in death) CARDIOMYOPATHY /Medical Due to (or as a consequence of): Examiner CONGESTIVE HEART FAILURE Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury be executed use as the burial-transit CARDIAC ARRYTHMIA that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown 9 Unknown signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably XX Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? HYPERLIPIDEMIA autopsy performed? 1 ☐ Yes 2 🗆 No 1 🗌 Yes XXNo Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) SISTER'S examiner' Other: 4 Nursing Home 5 Residence SXXOther (SpecifyRESIDENCE Hospital: 2 YYYes 2□No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of il or Attanding Prafter death. 28d. Describe how injury occurred Certification: XXNatural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 🗌 Homicide within 24 hours a To tha Funeral C XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and tyle of certifier 29c. License number 29d. Date signed (Month. Day. Year) D10125 OCTOBER 21, 2005 nome 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS PENDER, MD. 1160 VARNUM ST., NE WASHINGTON, DC 20017 31. Date filed (Month, Day, Year) . Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

OCT 2 1 2005

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** October | Marv Waugh 13, 2005 9:09 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ft. Washington Hospital Prince Georges Ft. Washington 6. Sex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 ☐ M 2 1 F Yrs. Director 1913 Washington, D.C. 577-16-9523 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumetic event, the Medical Examinat must be realised at Prince Georges Clinton 1 k Yes 2 No Director Maryland 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 12800 Jervis Street 20735 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 → No Specify: Black Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Edward Marshall Mary M. Armstrong 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Michael Aukard / Nephew 12800 Jervis Street Clinton, Md. 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Oct. 19,2005 Washington, D.C. 21. Signature of Funeral Service Cicensee 22. Name and Address of Facility
Alexander S. Po Pope Funeral Homes, P.A. 101085 Part1. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Myocardial Infarction /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran physician and Due to (or as a consequence of): by Physician/Medical for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Dehydration 3 Probably 4 □Unknown 1 ☐ Yes 2√∑ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Malnutrition autopsy page rmed? 2⊟No 1 Yes 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After or Attending 5 Pending 1 XNatural 1 ☐ Yes 2 ☐ No investigation death 2 Accident the Director: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Thomicide To the Hospital or within 24 hours at To the Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1)0036051 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Narasimhal, M.D. 11711 Livingston Rd. Ft. Washington, Md. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiepe 05 35936

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	1.		For State Regis		a	r	

Physicia /Medic Examin

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neture;' or items 23a or 28s-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physicien: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

State Registrar

Registrar						Cel	rtificate c	or De	aın			Reg	No.		
1. Decedent's Nam	e (First, Mida	de, Last)									2. Date of	Death	D		3. Time of Death
Gil	lbert N	Mauri	ce Wo	bod							Octob	er 1	.3, 20)05	14:05 PM
4a. Facility Name (4b. City, Tow	n. or Loc	cation o		OCCOD			y of Death	14.05 1
		, 3		,			Capito							•	rge's
1621 Nova		6. Sex		7 Age	(In yrs. last bi	irthday)			Under		8. Date of	f Birth		T	lace (State or Foreign
,			1 2□F	7. Ago	50	Yrs.	Months Da		lours	Min.	July	Day, Y	ear)	Cour	ntry)
227-78-7				<u> </u>	50		l				July	25,	1900	wası	nington,D.
Usual Residence o	10b. Count	v			10c. City, Tov	vn or Lo	cation							1	0d. Inside City Limits
Ì		,			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,										1 X Yes 2 No
Virginia					Bran	ichv	ille					.,			
10e. Street and Nu	mber						10f. Zip Cod					1	. Citizen of		•
33254 Th	e Hall	Rd.					2382	8					Unite	d Sta	tes
Virginia 10e. Street and Nu 33254 The 11. Marital Status 1 Never Marr 3 Widowed (Spector) Elementary/Seccor) 17. Father's Name		12	. Was Dec	cedent E	ver in U.S.	13.	Was Decedent	of Hispa	nic Ori	gin? (Sp	ecify Yes o	No-		ce - Americ	
1 Never Marr	ried 2 Ma	ben	1 TYes	2 X N	0		f Yes, specify (i, Puerio	rican, etc.)		ick, White,	etc. .ack
3 Widowed	4 Divorce	d	If Yes, G Year or I	ive Dates:			1 ☐ Yes 2 X ☐	No 5	pecify:				Speci	fy: DI	ack
	15. Decede	nt's Educa	tion		16a	. Dece	dent's Usual Oc	cupation	n			16	b. Kind of E	Business/Inc	dustry
(Spec	cify only highe	est grade o	completed,			(Give	kind of work do DO NOT use re	ne durir tired)	ng mos	t of work	ing				,
Elementary/Seco	ondary (0-12)		College ((1-4or 5+	-)		sabled							N/A	
17. Father's Name	(First. Middle	, Last)						18	. Mothe	r's Nam	e (First, Mic	ddle Ma			
Gilbert											de M.			-,	
19a. Informant's N	lame/Relation	iship (Type	, Print)		191	b. Mailir	ng Address (Str	eet and	Numbe	er or Rur	ai Route Nu	ım <i>b</i> er, C	ity or Town	, State, Zip	Code)
Alonzo	Wood /	Brot	her				Narrov		f D	r. L	argo,	Md.	207	74	
20a. Method of Dis	position			_	20b. Place o	of Dispo	sition (Name of	olace)	1	-	Date	20	c. Location	· City or To	wn, State
1 Burial 2 4 □ Donation			noval from	State		-	litan		0	ct.2	2,200.	5 A1	exand	ria,	Va.
21. Signature of Fu		- 4						dress of	f-Facilit	346	T7	. 1	71	T) ^	
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all all	My	Jus	sk-"	70	165									1	
23a. Part1. Enter to shock, or hea	art failure. Lis	or compale stonly one	cause on	each line	ine death. Do e.	not ent	er the mode of	ayıng, sı	uch as	cardiac	or respirato	ry arrest		1	Approximate Interval Between
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resulting in death)		(a.	Due to	(or as a	consequence		pu.	0- 1-							
Sequentially list co	onditions,	b	Due to	(or as a	achaupeanca.	σij.									
Cause (Disease or	erfying . r injury	<													
that initiated events resulting in death)		C.	Due to	oras a	consequence	of):			-						
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IF FEMALE:		1											1		
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in the past 12	□ No		4☐Preg	nant at t	ime of death		Other (specify						M	onth	Day Year
9 Unknown	1		9□ Unkr	IOWII											
Part II. Other signi	ficant condit	tions contr	ibuting to d	death but	t not resulting	in the u	nderlying cause	given in	Part I.		23e. D	id tobac	co use con	tribute to th	ne cause of death?
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examiner? **Mail: Yes 2 1	No	Ho	spital:	Inpatien	t 2 ER/O	utpation	t 3 DOA	O+					a a Mont	her /Spec-4	Scene
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1 □Natural	5 Pendi		(Moi	nth, Day	Year)	Injury		Nork?	2			,	1 10	_	
2 ☐ Accident 3 ☐ Suicide	6 🗆 Could	tigation	Tourl	10 ((3	1	136	7/1021		- 1		Jet	Tec	shul		
+ Homicide		mined	28e. Ptac	e of Injui ding. etc.	(Specify)	,	eet, factory, offi	СӨ			City or	Town, S	State) /62	oer or Rura	l Route Number,
•			for	not on	_ Sid	e wa	ye				Conto	1 Hig	ity ,	nongli	and
29a. Certifier (Check only	1 Certifyi	ing Physic	ien: To th	e best of	f my knowledg	e, death	occurred at the	e time, c	date an	d place,	and due to	the calu	a(c) and m	20001 25 5	ated.
one)	2 CJ IMBUICA		and mai	nner stat	ed.	- COUNTY	- esugation, in fi	y opinic	л, цөа	ui occuri	eu at the tir	ite, date	and place.	and due to	ute cause(s)
29b. Signature and	title of certifi	ier					29c. Lic					29d	Date signe	ed (Month, I	Day, Year)
1	1	11	Y .	/			(CME	r			00	tober	14	2005
100	code.	u,	409	X	ath (lt-= co :	(T	Orint) III	Pan	n s	roo	t. Po				and 21201
30. Name and add	4	4. 6	pieted lu	D of de	ain (Item 23a)	(туре,	Print)	/./	ıι ₩.	#T.GG	118	الباداة	$\alpha \cap \alpha$	HALL YALL	CLES MERCA
THEODS		cking	11/	Paristr	de Signatura	114	KI ID	UM	imo	re	ma.	Al	CU 1		
31. Date filed (Mor	J. 19.		32	rregistrai	r's Signature		- 40								
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			-	3		1									

				partment of Health and Me ertificate of Death	ental Hygie	
	Physici /Medic		1. Decedent's Name (First, Middle, Last) George Francis Zverina		2. Date of Death	Day Year 3. Time of Death 3:00A M
	Examin	er,	4a. Facility Name (If not institution, give street and number) 14 Winterberry Court 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	4b. City, Town, or Location of Death La Plata y) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	4c. County of Death Charles 9. Birthplace (State or Foreign
	Funeral Director		216-30-4037 1XM 2□ F 76 Yrs. Usual Residence of Decedent	Months Days Hours Min. May	14, 19	ear) Country)
	ne Marylan 8e-f show	Director	10a. State	ata		10d. Inside City Limits
	23a or 2		14 Winterberry Court	10f. Zip Code 20646	10g.	Citizen of What Country? USA
036	urs after dea el', or Items	by Funerai	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 13 Yes 2 □ No 17 Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto R	city Yes or No- lican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other then "naturel; or items 23a or 28e-1 show other traumatic event, it is Medical Estringtrate the retilited at	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of working DO NOT use retired) LWYCT	g 16b	Law
Maryland 2	uld be filed Aental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last) George Charles Zverina	18. Mother's Name (den Sumame)
	is 1 and 2 should of Health and Men item 27 Is marke other traumatic			ling Address (Street and Number or Rural Winterberry Ct.		
altimore,	permit. Pages 1 Department of He Important: If iten any injury or oth		'4 □Donation 5 □Other (Specify) Mt. Res	ematory or other place) t Cemetery 10/24	4/05 La	a Plata, Maryland
Ba	permit Depar Impor any in		21. Signature of Funeral Service Licensee M00945 23a. Part. Enter the disease, or complications that caused the death. Do not en	22. Name and Address of Facility AREHART - ECHOLS F P.O. BOX 567, LA	FUNERAL PLATA	HOME, P.A.
	Pnysician /Medical		shock, of heart failure. List only one cause on each line.	EUKEMÎA	a a a a a a a a a a a a a a a a a a a	Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):			
O. Box 6	death certifi e attending d for use as	Physician/Mec		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
rds, P	The law requires that the te has been signed by thi rage 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to the cause of death? 2 No 3 Probably 4 Unknown
Il Records,		Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 □ No
f Vital	physiclen: Th this certificate al director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 XNo Hospital: 1 Inpatient 2 ER/Outpatie	26. Place of Death /		6 □Other (Specify)
Division of	Attending Pr death. ctor: After th y the funeral	Certification:	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation		d. Describe how in	
DIX	To the Hospitel or Attending Physicien: whith 24 hours after deals after deals for the Funerel Director: After this certifical completely filled in by the funeral director;		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		City or Town, St	
	To the Hosp within 24 ho To the Fune completely fi	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurred	at the time, date :	and place, and due to the cause(s)
	To the within To the comple	2	29b. Signature and title of certifier Korff Hattle	29c. License number	29d.	Date signed (Month, Day, Year)
5	BIFFI		30. Name and address of person who completed cause of death (Item 23a) (Type	.Print) aPlata M	02	0646
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 4 2005 32. Resistrar's Signature	Grantes		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 5:30 р м 2, Stephen Zeiba, Jr. October | 2005 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 3226 Escapade Circle Riva Anne Arundel 8. Date of Birth (Month, Day, Year) Aug. 25, 1920 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Days 1₩ 2□F Massachussetts 041-07-1010 85 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2√2 No Riva Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21140 United States 3226 Escapade Circle 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1. GYes 2 No If AYes, Give Year or Dates: WW II 1 ☐ Never Married 2X Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction Project Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ethel Field Stephen Zeiba 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (wife) 3226 Escapade Circle Riva, MD 21140 Doris Reed-Zeiba 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Advent Funeral Ser. Oct.21,2005 Falls CHurch, VA. 21. Signature of Foneral Service Licensee 22. Name and Address of Facility Advent Funeral & Cremation Ser. M00982 42 Hudson St. Suite 110 Annapolis, MD. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 2200 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 esidence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 TYes Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie 29d. Date signed (Month, Day, Year) 29b. Signature 30. Name and address of 31. Date filed (Month, Day, Year)

State Registrar

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Division of Vital Records,

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Baltimore, Maryland 21215-0036

2005

State of Maryland / Department of Health and Mental Hygiene, For State Registra Reg. No. Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** October 20, а 2005 2:14 Najaf Zada aka Regina Orujevskaya /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days Hours Min 1 □ M 2 🔀 F Yrs. Director August 3, 1937 Russia None Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County r then "naturel", or items 23s or 28s-f show the Medical Expressional be notified at 1 ☐ Yes 2 ☑ No Montgomery Potomac Maryland Direct 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 1409 Fallswood Drive 20854 Azerbaijan Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married , or ! Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: Specify:White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 5+ Biologist University injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Larisa Unknown Mose Orujevesky and N 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) it of Health : 1409 Fallswood Drive, Potomac, MD 20854 Anna Duran/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition October 22 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Importent: If Baku, Azerbaijan Jasamal Cemetery 4 □Donation 5 □ Other (Specify) 2005 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. any ir MD 20901 500 University Blvd, W, Silver Spring, 23a. Part 1. Onter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sudden Condiac **Physician** minula /Medical Due to (or as a consequence of) Examiner minute vima Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine nding physicien and use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical attending 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No Month Year page 2 should be detached for 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has **3**€ No 1 Yes completely filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 20 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death 2 ☐ Accident Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 633 10120165 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Poopak G. Bakhtiari, M.D. 9900 Medical Center Drive, Rockville, MD 20852 31. Date filed (Month, Day, Year) 32 Registrar's Signature State OCT 21 2005 Registrar

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	Physic /Medi		Decedent's Name (First, Middl Lin	_{da I.} Atki	ns				2. Date of D	Day # Yes	
	Examir		4a. Fecility Name (If not institution FR9n Kliw S9) 5. Social Security Number	vare Hosp	:421	ast birthday)	4b. City, Town,	or Location of De Edale	eath /	4c. County of D	timore
18,	- Funeral Director		212-58-5644 Usual Residence of Decedent	1 □ M 2XF	54	Yrs.	Months Days			19,1951 M	Birthplace (State or Foreign Country) Aryland
	Maryland -f ehow	tor	10a. State 10b. County	timore	10c. City	r, Town or Loc	ssex				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
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N d A 5-0036	172 hours after death with the Maryland "nature!", or freme 23a or 28e-f ehow colcal Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	If Yes Give	?	If	Vas Decedent of Yes, specify Cub ☐ Yes 2 No		(Specify Yes or Nerto Rican, etc.)	14. Race - A Black, W Specify:™]	
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\	and 2 sho saith and 1 n 27 le ma er treuma		19a. Informant's Name/Relations Steve R.Atk		nd	19b. Mailing 1515	Alcon	and Number or bury Ro	Rural Route Number of Bal	ber, City or Town, State timore MD	a, <i>Zip C</i> ode) 21221
—————————————————————————————————————	Pages 1. ment of He ant: If Iten ury or oth		20a. Method of Disposition 1 XBurial 2 Cremation 4 Donation 5 Other (S		ce	metery, crem	ition (Name of atory or other pla 11Ceme	tery 11	Date / 11/05	20c. Location - City Baltimon	
Balt	permit. Depent Import		21. Signature of Funeral Service	Licensee On	nel	11 3	Name and Address Name and Nam	e Ave.	onnelly Baltim	FuneralHo	omeofEssex
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	/Medical Examiner	70		b. Due to (or as		5550	Failu	rke			
8760,	ate be executed thysician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c							
Division of Vital Records, P.O. Box 68		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 M No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3□6	Ectopic pregnanc Other (specify)	y		23d. Date of d Month	lelivery Day Year
rds, P	quires that the signed by all be detacted	þ	Part II. Other significant condition	ms contributing to death be	ut not resul	ting in the und	derlying cause giv	ven in Part I.		tobacco use contribute	to the cause of death? Probably 4 QUnknown
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Divi	To the Hospital or Atte within 24 hours after de To the Funeral Direct completely filled in by th		3 Suicide 6 Could a determine	ined 286. Place of Injurbuilding, etc	c. (Specify)				City or To	Street and Number or I wn, State)	
	the Hosp hin 24 ho the Fune	ledical	one)	g Physician: To the best of Examiner: On the basis of and manner sta	examination	ledge, death on and/or inve	occurred at the tir stigation, in my o	ne, date and place pinion, death occ	ce, and due to the curred at the time,	cause(s) and manner date and place, and di	as stated. ue to the cause(s)
•	To To COTT	Σ	29b. Signature and title of certifier	M	1	1	29c. Licens			29d. Date signed (Mor	
	10		30. Name and address of person	who completed cause of de	eath (Item 2	-	sint)	Sa. 2.4.4	c Down	RII	in 7th 2005 in Md. 21237
	Star Registra		31. Date filed (Month, Day, Year)		ar's Signatu	Ire South	E .	DUAR	C +1CIVE	1 th It make	1 11d. 21231)

State of Maryland / Department of Health and Mental Hygiene 0 0 5 35941 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician JOSEPH NOVEMBER 03 2005 \mathbf{E} ALLEN. JR. 12:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1117 Regina Drive Arhutus Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1**™**M 2□ F Days Hours Director 218-05-9450 86 Apr. 8,1919 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at 1 ☐ Yes 2 DHNo Directo Maryland Anne Arundel <u>Pasadena</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 7653 Lake Drive filed within 72 hours after death Funeral 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 ₩idowed 4 Divorced "natural", White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 N/Aevent, II <u>Maintenance Worker</u> Hospital 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be 27 is marked traumatic Joseph Allen, Sr. Dora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a :: If item 27 la or other train Gordon T. Allen, Sr. (Brother) 1117 Regina Drive Arbutus Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State tment of 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pag Department Important: I any injury o * 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Pk. 11/05/05 Elkridge, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A. fellens 3204 Mountain Road Pasadena, Maryland 21122 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, swock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cancer Monte /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to initiodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): certificate be executed physicien and the burial-transit Due to (or as a consequence of) Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery jo 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 MNo 9 ☐ Unknown 4 Pregnant at time of death Month Dav Year signed by the a 5 Other (specify) o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 ☐ Yes 2 🔀 No Division of Vital 1 ☐ Yes 2 ☐ 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 26. Place of Death (Check only one)
Other: 4 Nursing Home 5 Residence 6 V Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DDA 1 Yes 2 No Certification: To To the Hospital or Attending Phye within 24 hours after death.

To the Funeral Director: After this a completely filled in by the funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D39505 November 4, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 305 Hospital Dr. Glan Burnie, MD. 21061 n an 31. Date filed (Month, Day, Year) NOV 0 8 2005 2. Registrar's Signature State Registrar

			1 - For State Registrar	State of Maryla		rtment of F		Mental H	ygiene 0	5 35942
	Physic /Medi		1. Decedent's Name (First, Middle, La Richard R.	Allen				2. Date of D Month	Day	Year 3. Time of Death
	Examine Funeral Director	ner	5. Social Security Number 6. S	ryland Hosp	V fal s. last birthday) Yrs.		If Under 24 Hrs Hours Min.	R Date of R	irth Year) 0, 1930	
	he Maryland 8e-f show	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Prince		ity, Town or Loo Brandywi			000	0, 1930	10d, Inside City Limits 1 □ Yes 2 □ No
	th with the 23e or 2		10e. Street and Number 16401 River As	irport Road		10f. Zîp Code 2061:	3		10g. Citizen of W United S	ŕ
036	d within 72 hours after death with the Maryland sjene. Jene. I than "neturel", or Items 23e or 28e-1 show The Medical Evantient met be redified at	by Funeral	11. Marital Status ¹X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in t Armed Forces? YWYes 2 No KO 11 Yes, Give Year or Dates:	roon	/as Decedent of Hi Yes, specify Cuba □ Yes & No	ispanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or N o Rican, etc.)	o- 14. Race	- American Indian, , White, etc.
21215-0036	within 72 ane. than "ne	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5+)	(Give K	ent's Usual Occupa cind of work done of O NOT use retired Room Cle	during most of wor)	king	16b. Kind of Bus	
Maryland 2	be file tal Hyg d othe event,	To Be Co	17. Father's Name (First, Middle, Last) Richard R. Al	len_			18. Mother's Nan	ian E.	e, <i>Maiden Sumame</i> Lynch	,
	s 1 and 2 if Health a item 27 Is other trau		William J. Aller 20a Mathod of Disposition	(Brother)	16401		irport Ro	oad, Bra	oer, City or Town, S andywine, 20c. Location - C	
Baltimore,	permit. Pages Department of I Importent: If it any injury or or once.		A Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify 21. Signature of Juneza Service Crem	Y Ma	ryland 22.	Veterans Name and Addres	Cemeters	T Funera		am, Maryland nc 6633 Old
	Medical be executed by the purial-transit as	edical Examiner	23a. Part1. Enter the disease, or composition, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, Leading to financiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each line.	quence of):	- 0			eert Di	Approximate Interval Between Onset and Death
F.O. DOX 6	ath cer ttendin or use	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c, If yes, outcome of pregn 1 □ Live birth 2 □ Fete 4 □ Pregnant at time of c 9 □ Unknown	al death 3 □E	ectopic pregnancy Other (specify)			23d. Date Month	,
necolds, r	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions or	intributing to death but not res	sulting in the unc	lerlying cause give	n in Part I.		obacco use <i>co</i> ntnb Yes 2 □ No 3	ute to the cause of death?
		e Completed	25. Was case referred to medical						psy prior dea	ore autopsy findings available or to completion of cause of ath?
	this certificaral director, p	ToB	examiner?	Hospital: 1 ☐ Inpatient 2	ER/Outpatient	3□ DOA Other	26. Place of Deat 4 □ Nursing Ho		one) dence 6 □Other	(Specify)
io lioisivio	After fune	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		at		how injury occurred	
2	24 hours after death		4 Homicide determined	28e. Place of Injury - At he building, etc. (Specifical): To the best of my know	(y) 			City or Tov	vn, State)	or Rural Route Number,
	within 24 h	Medical	one)	rsician: To the best of my kno iner: On the basis of examina and manner stated.	ation and/or inve	stigation, in my opi	e, date and place, nion, death occur	and due to the red at the time,	cause(s) and mann date and place, and	er as stated. I due to the cause(s)
	Note:	2	29b. Signature and title of certifier	Alatio	₹	29c. License			29d. Date signed (M	
1			30. Name and address of person who			int)	3) / 1	c 1	NOV end	ars/12005
P	Sta Registra		SALVA don Sylv- 31. Date filed (Month, Day, Year) NOV 0.8	37 ex 300/ 32. Registrar's Signa		Tal D	rine	Ch ever	ily M	My / AN d

			For State Registrar	State of Marylan	d / Depa <i>Cei</i>	artment of F rtificate of	Health and N <i>Death</i>		ene 0 0 5	35943
	Physici		Decedent's Name (First, Middle, Last) IRMA		APP	LEFELD		2. Date of Death		3. Time of Death 8:55 A M
>	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town, o	or Location of Death	·	4c. County of Deat	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, MAY 29,	9 Birt	hplace (State or Foreign untry)
	yland sow		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits
	8a-f sh	Director		TIMORE	PIK	ESVILLE				1 ☐ Yes 2 No
	with th	Dire	10e. Street and Number 725 MT. WILSON I	ΔNF		10f. Zip Code	21208	10	g. Citizen of What Co	USA
	sms 2:	Funerai		Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H	dispanic Origin? (Si an, Mexican, Puerto	pecify Yes or No- Dican, etc.)	14. Race - Ame Black, White	rican Indian,
036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show ha Mudical Expirit or trust Le modified at	ρ	1 ☐ Never Married 2 ☐ Married 3 💢 Widowed 4 ☐ Divorced	1 □Yes 2 X No If Yes, Give Year or Dates:	1	1 □ Yes 21X No			Specify:	WHITE
5-0	"natur	ieted	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of won	king	6b. Kind of Business/	Industry
21215-0036	d withir giene. or then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		TIVE SEC	•		BANKING	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or itsms 23a or 28a-f show any injury or other traumatic avant, the Mudical Expirition or must be notified at another.	To Be C	17. Father's Name (First, Middle, Last) DAVID		ROS	EN	18. Mother's Nam BESSIE	ne (First, Middle, M	faiden Sumame)	(UNKNOWN)
lary	2 shou and M Is mar sumat	-	19a. Informant's Name/Relationship (Typ		1				City or Town, State, 2	
	1 and Health em 27 sthar tr		STANLEY MINKEN , 20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of	-NEAVIT R		BOZMAN, MD	
E O	Pages nent of int: If it		1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	-	natory or other pla EL CEMETI	1	7/2005	BALTIMORE	, MD
Baltimore,	permit. Depertrimports sny Inju		21. Signature of Funeral Service License	Cettle		2. Name and Address	. 3		SON & BROS	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only on	e cause on each line.	n. Do not ent	er the mode of dyii	ng, such as cardiac	or respiratory arre		Approximate Interval Between Onset and Death
)	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			- 16.	rombo	2130		Oriset and Death
	Examiner		Sequentially list conditions	Due to (or as a consequ	uence ot):					
	pe per sit	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or se a consequ	uanea of):					
, ,	cate be executed physicien and the burial-transi	Examiner	that initiated events cresulting in death) Last	Due to (or as a consequ	uence of):			_		
68760,	physici the bu	edical								
Box	ie death certificate be executed the attending physicien and hed for use as the burial-transit	Physician/Me	in the past 12 months? 1 □ Yes 2 ☑ No	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	Ideath 3□	Ectopic pregnanc Other (specify)	у		23d. Date of deli Month	ivery Day Year
ls, P.O.	ss that the gned by se detac	þ	9 ☐ Unknown Part II. Other significant conditions con	tributing to death but not resu	ulting in the u	nderlying cause gr	ven in Part I.	23e. Did tob	acco use contribute to	the cause of death?
of Vital Records,	w require been si should b	Completed						24a. Was an		topsy findings available
Re	hysicien: The law his certificate has t Il director, page 2 s	ошо						autopsy perform	prior to death?	completion of cause of 2□ No
Vita	Physicism: this certificatal director.	Be	25. Was case referred to medical examiner?	ospital:		O#	205	th (Check only one	·	
n of	A ~ G	on: To	1 ☐ Yes 2 ☑ No 27. Manner	28a. Oate of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Inju	ry at rk?	ome 5 Resider	nce 6 □Other (Spec w injury occurred	cify)
Division	To the Hospitel or Attending I within 24 hours efter death. To the Funeral Director: After completely filled in by the funer	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, str y)]Yes 2□No	28f. Location (Str. City or Town,	eet and Number or Ru , State)	ral Route Number,
اب	To the Hospitel or within 24 hours effer To the Funeral Dir completely filled in	edical Ce	(Check only 2 Medical Examin	ician: To the best of my kno ner: On the basis of examina						
	oths omplet	Med	29b. Signature and the of certifier	and manner stated	· · · · · ·	29c. Licens	se number	29	d. Date signed (Monti	n, Day, Year)
	+		Deet	10/		DI	5878	2 /	Voventes	5, 2005
	10		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type.	Print)	s 8/2	2112	6	
	Sta		31. Date filed (Month, Day, Year)	32. Redistrar's Signa	ture	Souli	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
	Registi	C.	70000	LUUU KARARA	No. V					

			For State Registrar	State of	Marylan		artmen rtificat					eg. No.	005		
Å,	Physicia /Medic		1. Decedent's Name (First, Middle BARBARA COE								OVEMB	ER ^{Day} (
	Examin		4a. Facility Name (If not institution, BLAKEHURST				TOT	VSON	_			В	ALTIM	ORE	
	Funeral Director		400-24-5618	6. Sex 1 □ M 2 □ 🟋	7. Age (In yrs.	last birthday, Yrs.	If Under Months		If Under Hours	Min. A	Date of Birth (Month, Oay UG • 2	9,1	917 K	thplace (State or F	oreign
Maryland	fahow fited at	tor	Usual Residence of Decedent 10a. State 10b. County MD BALT 3	MORE	10c. Cit	y, Town or L								10d. Inside City	
death with the Maryland	3a or 28a at be noti	ai Direc	10e. Street and Number 1055 WEST JO	PPA ROA	D apt	531	10f. Zip		204		1	-	en of What Co	ountry?	
5-0036 72 hours after deat	or the	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 ∰Widowed 4 ☐ Divorced	12. Was Dece Armed For 1 Yes If Yes, Give Year or Da	ces? 2 [X No e		Was Dece If Yes, spe 1 Yes				fy Yes or No- can, etc.)		4. Race - Ame Black, Whi Specify: WI		
21215-0 d within 72 ha	natu	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	s Education t grade completed) College (1-	4or 5+)		dent's Usu kind of wo DO NOT u			st of working	,		d of Business		
Maryland 2	and Mental Hygiene. is marked other than sumatic event, Its M.	To Be C	17. Father's Name (First, Middle, I	СОВВ					MAF	RY SA	First, Middle, M	D		7- C- d-)	
altimore, Mar	rtment of Health rtant: If Item 27 Ijury or other tr		19a. Informant's Name/Relationsh JOHN C . G . F 20a. Method of Disposition 1 Burial 2 X Cremation 4 Donation 5 Other (Sp. 21. Signature of Funeral Service I	BOYCE, JR 3 □Removal from Secity)	20b. F	DUN Place of Disponentery, cre REEN	CAN osition (Nai matory or o	HILI me of other place C CE	L RD	. BOX	/2005	UTL 20c. Loc BAI	ER, Mication - City or	D 21023	
Ba	Depar Impo any ir		23a. Part1. Enter the disease, or	LONACO	used the deat	140	1692	24 Y	ORK	ROAD	MONK	TON			
1	nysician /Medical xaminer		shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a.	or as conseq	an Cl	-	as of dylli	g, 34011 43	our dias or r				Interval Between Onset and Dea	
760, te be executed	ysician and	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	or as a conseq										
ords, P.O. Box 68 requires that the death certifical	gned by the attending phy be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregpant in the past 12 months? 1 □ Yes 2 ℚ No 9 □ Unknown		nth 2 ☐ Feta antat time of d	il death 3[⊒Ectopic p ⊒ Other <i>(sp</i>					23	3d. Date of de Month	livery Day Yea	ar
ords, P.	been signed by	þ	Part II. Other significant conditio	ns contributing to de	1	ulting in the u	1	ause give	en in Part I	l. ——		s 2		o the cause of dea robably 4 Unk	
I Rec The law	ate has b	Completed									24a. Was an autops perform	ned?	24b. Were at prior to death?	utopsy findings ava completion of caus 2 No	ailable se of
of Vita	After this certificate funeral director, pag	n: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	28a. Date o	npatient 2	ER/Outpatie		OA Oth	er: 4□Nu	ursing Home	Check only of 5 Neside d. Describe ho			ocify)	
Division I or Attending	after deatl Director: in by the	Certification:	1 Matural 5 Pending 2 Accident Investig 3 Suicide 6 Could red	ation ot be 28e. Place	of Injury - At h	ome, farm, st	М	1 🗆	Yes 2□		f. Location (St. City or Town		Number or R	ural Route Numbe	r,
- Hospital	24 hours a Funeral letely filled	Medica Ce		g Physician: To the examiner: On the ba and mann	isis of examina										
To the	within To th compl	Me	29b. Signature and title of certifier	10	m		29	C. Licensi	F16		2	Α.	signed (Mont		
	10		30. Name and a ress if person	MO 60	W/ N	Charles	Print)	4560	5	Tousa	n, MD	2	17.0		
Qr L	Sta		31. Date filed (Month, Day, Year)	32. R	gistrar's Signa	ature 20	and the	9					-		

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2005 Jean Т. Bosetti November 05:10 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Center Saint Joseph Medical Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Months Days Hours Min. March3, 1918 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** PA 1 ☐ M 2 ☐ XF Director 186-20-2083 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 23a or 28a-f ehow The Medical Examiner must be notified at 1 ☑ Yes 2 ☐ No MD Director Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21234 8800 Old Harford Road deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. "natural", or items 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: White ۾ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) BurdindsClothingCo Elementary/Secondary (0-12) College (1-4or 5+) Buyer permit. Pages 1 and 2 should be filed will Depetiment of Health and Mental Hygien. Importent: If item 27 Is marked other thu any injury or other traumatic avant, Ina. once. 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sam Bosetti unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Bosetti 5229TorringtonCt. WhiteMarsh Md 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State NorthLauderdale 11/9/05 QueenofHeaven 4 □Donation 5 □ Other (Specify) Florida 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service Licensee 300 Mace Ave. Baltimore MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do of enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Acute Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Urosepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine sit The law requires that the death certificate be executed ettending physicien and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760, by Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day Year Month 4☐Pregnant at time of death 5 Other (specify) ned by the e 9□ Unknown 9 Unknown signed | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Atrial Fibrillation 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed es 2 1 🗌 Yes 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient P 2 ER/Outpatient 3 DOA After this 28a. D. te of Injury (Month, Day Year) 28b. Time of 27. Magner of Douth 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours efter death

To the Funeral Director:
completely filled in by the 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0310 ,2015 Dovember mun mello m.O D 41410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mehta, M. D. (
32 Registrar's Signature Osler Drive Towson, Maryland 21204 Joginder Paul 7601 31. Date filed (Month, Day, Year) State NOV 0 8 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 5 Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last)-Month **Physician** 2005 avid /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE Center OUSSOR If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 M 2 ☐ F . Age (In yrs. last birthday) Funeral Months Days Hours Min 2733 OHIO Director Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Yes 2 No BALDMORE Funeral Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number r than "natural", or itema 23a or If a Medical Examiner must be a 21082 4524 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No Itoes. Give 11. Marital Status 1 Never Married 2 Married 1□ Yes 2 No Specify Baltimore, Maryland 21215-0036 Completed by 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) permit. Peges 1 and 2 should be filed withi Depertment of Heelth and Mental Hygiene. Important: If item 27 Ia marked othar than tan +tm Maintainence toreman 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) M Mocci 19b. Mailing Address (Street and Number, or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joy Co Mews vow -dave

20a. Method of Disposition

1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Narde of cemetery, crematory or other place) 2108 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 325 York Rd. Timonium WID 21. Signature of Funeral Service Peaceful Alternatives Funcial & Cremation Contain Approximate Interval Between Onset an Death 23a. Part 1. Enter the disea * , or com /lic tio * that baused the shock, or heart failure List only on cause on e ich line. death. Do not enter the pole of dying, such as cardiac or respiratory arrest, tmmediate Cause (Final disease or condition resulting in death) Carre Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examine Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? res 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOSPICE 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death al or Attanding P s after death. Il Diractor: After Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel o within 24 hours aft To the Funeral Di Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Nevember 8 2005 NW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 N. Charles St Powers, ms AARON CHARLES WD 31. Date filed (Month, Day, Year) 32 Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

2005

November

8 2005

Discosing Foundation from street Accept Lead 1 20 Copy Town of Exemption (Page 1 and Supplied Page 1 and Copy Town of Exemption (Page 2 and Copy Town of Exe				For State Registrar	State of Maryla		artment o				giene Reg. No. ()5	35947
Commonwealth Comm		Dhysisi	2.0								Day		
Second Second Promoters Promoters 225 Lake Avenue 213-18-6188 5. Second Second Promoters 10		_					4h Cin Tau	and mostiv	on of Dooth	11			6:30 A™
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Discretized Control		Funeral		5. Social Security Number 6. Sex	7. Age (In yi	s. last birthday)	If Under 1 Y	ear If Und	der 24 Hrs.	(Month, Da	h v. Year)	9. Birthp	lace (State or Foreign try)
To Sheel and Name Part of the part of the	П			210-10-0100	79	Yrs.				Jan 11	, 1926	Mar	yland
The part of the pa		land ow			10c.	City, Town or Lo	ocation					1	Od. Inside City Limits
The part of the pa		Mary B-f sh	tor	Maryland N/A		Baltin	nore						1√ Yes 2 No
The part of the pa		ith the	Dire		Avonuo		10f. Zip Co		2		•		try?
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9 Unknown Part I. Other significant conditions conjusting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?	×o	h certif	In/Me				Tectopic pregr	nancv					•
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The property of the control of the c	<u>α</u>	that the			rebuting to death but not	resulting in the	inderlying caus	se given in Pa	art I.	23e. Did to	obacco use co	ntribute to th	ne cause of death?
Cot start states Cot start	rds	quires an sign uld be		Hyperteusion -1	Grmay F	ts took	Udsec	ne		101	∕es 2□No	3 Prob	ably 4 Hinknown
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 28. Manner of Death 28. Describe how injury occurred 28. Place of Death (Check only one) 28. Describe how injury occurred 28. Describe how	eco	law re as bec 2 sho	plet	Hyperlipideoria						autop	sy	prior to con	
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State Registrar MOV 0 8 2005 State		10			mpleted cause of death (Item 23a) (Type	, Print)		- 01	0 1		. 1 ~	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar					0127 Cu	2 rchée	the peace	1 20	08 Gle	1 China	بالرمسوا	one (1	VO
					32 Registrar's Si	gnature	ortes						

		For State Registrar	State of I	Marylan				ealth and Death		F	eg. No.	005	35948
Physici /Medic	41	Decedent's Name (First, Middle	LORRAINI	E DEN	ISE BL				1	Month	Day 1	2005	
Examir	_	4a. Facility Name (If not institution UNI	ON MEMORIAL	HOSPIT					LTIM			unty of Death	
Funeral Director		5. Social Security Number	6. Sex 7. 1 ☐ M 2 🕱 F	Age (In yrs.	last birthday) Yrs.	Months Months	n 1 Year Days	If Under 24 Hours M	lin. 8	Date of Birtl (Month, Day Jul 7,	, Year)	9. Birth	place (State or Foreign untry) MD
Maryland f ehow	or	Usual Residence of Decedent 10a. State 10b. County MD		10c. Cit	y, Town or L	ocation	BAL	TIMORE					10d. Inside City Limits 1 Yes 2 □ No
with the Page or 28a-	Direct	10e. Street and Number 4415 MARBLE HAL	L RD			10f. Zi	Code	21218			l 0g. Citizen	of What Cor	
be filed within 72 hours after death with the Maryland that Hygiene. Idea Hygiene. Idea ther than "natural", or iteme 23e or 28e-f ehow event, the Medical Examinational be incultived at	by Funeral Director	11. Marital Status 1 Mever Married 2 Mar 3 Widowed 4 Divorced	If Yes, Give	es? □ X No		Was Dece if Yes, spe 1 Yes		ispanic Origin? in, Mexican, Pu Specify:	' (Speci uerto Ri	fy Yes or No- can, etc.)		Race - Amer Black, White ecify:	
within 72 hou ene. than "natura	Completed		nt's Education st grade completed) College (1-4	or 5+)	16a. Dece (Give life.	dent's Usu kind of we DO NOT	ork done d se retired	ation during most of the	working		16b. Kind o	DOME	
II y all a C I C in the proof of the control of the	To Be C	17. Father's Name (First, Middle,	Last) OY BLAKENEY					18. Mother's f	Name (i		Maiden Sur		
ore, individually lail stand 2 should b of Health and Ment fitem 27 is marked r other traumatic e		19a. Informant's Name/Relations PATRICIA ANN GA						and Number or RD RD BA					
mit. Pages 1 a partment of Her portent: if item injury or others.		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (5			Place of Disposemetery, cre BAYV	osition (Na matory or IEW CI	other plac		Dat 1	1/05/05	20c. Locati	on - City or 1	
permit. Pages Department of importent: if if eny injury or o		21. Signature of Funeral Service	hilto			N 1	IILLER 639 NO			<i>N</i> AY BAL	TIMORI	P.C. E, MARY	LAND 21213
Physician /Medical Examiner	Examiner	23a. Parl 1. Enter the disease of shock, or heart failure. List immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a	h line.	ccd	ter the mo	se or ayın	g, such as card	alac or I	espiratory an	est,		Approximate Interval Between Onset and Death MIÑU
that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 200	d23c. If yes, outco	h 2 ∏ Feta ntattime of o	ancy al death 3	⊒Ectopic p					23d.	Date of deliment	very Day Year
	þ	Part II. Other significant conditi	ons contributing to dea	th but not res	sulting in the I	underlying	cause givi	en in Part I.		23e. Did to			the cause of death?
The law ate has b	Completed								_	24a. Was autop perfor 1 Yes	sy		topsy findings available completion of cause of
Attending Physicien: The rideath. ector: After this certificate by the funeral director, pag	atlon: To Be	25. Was case referred to medical examiner? 1 Yes Vo 27. Manner of Death Natural	Hospital: 28a. Date of		ER/Outpatie 28b. Time o Injury		28c. Injun Worl	er: 4 ☐ Nursin	g Home	Check only of 5 Resided. Describe h	ence 6 🗆		cify)
To the Hospitel or Attending within 24 hours effer death. To the Funeral Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deterr	nined 288. Place of building	, etc. (Speci	fy)				28	City or Tow	n, State)		ral Route Number,
the Hospi in 24 hou the Funer pletely fill	Medical	29a. Certifier Certifyi (Check only one)	ng Physician: To the b I Examiner: On the bas and manne	is of examina	owledge, dea ation and/or i	nvestigatio	n, in my o	pinion, death o	ace, an	I at the time, o	late and pla	ce, and due	to the cause(s)
To t To 1	×	29b. Signature and title of certific	er	MD		A	C 24	e number -3894	<u>b</u>		li 2	Jo 5	n, Day, Year)
St. Regist	ate	30. Name and address of person Marita Mike 31. Date filed (Month, Day, Year NOV 0 8	MO Uni	of death (Iter	m 23a) (Type	Print)	ospi	tal	20	OLE.	Univer	verty)	PICWY

Registrar

ician dical	1	1. Decedent's Name (First, Middle, BTLLI	Last) Nellie	Billi ELL	2	Mo 1	0 2	Day Yee	105 6 PM
niner		la. Facility Name (If not institution,	give street and number)		4b. City, Town, or Loca	ation of Death		4c. County of D	eath
		Lorien Frankford	7.4	. // last bi	Baltimor		o of Righ		Birthplace (State or Foreig
al or	5	5. Social Security Number 218–22–5845	6. Sex 7. Ag	ge (In yrs. last bi 95		ours Min. 08-	e of Birth nth, Day, Ye 16-1910	ar) M.	Country) aryland
4	T	Usual Residence of Decedent							
		10a. State 10b. County		10c. City, Tow					10d. Inside City Limits
Director	3	MD	NA		Baltimore				1X Yes 2 □ No
Dire		10e. Street and Number			10f. Zip Code		10g.	Citizen of What	: Country?
		2705 Mosher Stree		Cyca is U.C.	21216		s or No	USA 14 Bace - A	mencan Indian,
Filneral		 Marital Status Never Married 2 Marrie 	12. Was Decedent Armed Forces? ed 1 Yes 2	?	13. Was Decedent of Hispan If Yes, specify Cuban, Me	exican, Puerto Rican,	etc.)		/hite, etc.
2	<u>~</u>	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 1 No Sp	pecify:		Specify: B	lack
to	D C	15. Decedent'	's Education	16a	Decedent's Usual Occupation (Give kind of work done during	a most of working	16b	. Kind of Busine	ess/Industry
oing		(Specify only highest Elementary/Secondary (0-12)	College (1-4or	5+)	(Give kind of work done during life. DO NOT use retired)	g moot or wearing		Church	
Completed	5 -	8			Pastor	Mother's Name (First,	Adiadalla Adair		
å	9	17. Father's Name (First, Middle, L	Last)		18.			den Sumame)	
F	2 _	Lemuel Turner 19a. Informant's Name/Relationsh	nin (Tuna Print)	19	b. Mailing Address (Street and A	May F. Tu		tv or Town. State	te. Zip Code)
-		Velvo Dorsett/ Gra			3719 Leonard Drive				
1	-	20a. Method of Disposition	iraniece	100	of Disposition (Name of ery, crematory or other place)	Date		. Location - City	or Town, State
		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		'	Memorial Park	10-28-05	Pa	ndallstow	m MD
	-	21. Signature of Funeral Service L		KIIIg F	22. Name and Address of		IVA	IIIIIIII COW.	11, 140
	-	1/2	1-2		Wylie Funeral	Home P.A. 63	8 N.Gib	mor Stree	t Balto, MD 212
n al er	Iner	Immediate Cause (Final disease or condition resulting in death)	a. A D VI	d the death. Do ine. Enc		ich as cardiac or respii	atory arrest,		Approximate Interval Between Onset and Death
	Exa	Immediate Cause (Final disease or condition	a. Due to (or as	a consequence) (a) (b):	ich as cardiac or respii	atory arrest,		Approximate Interval Between Onset and Death
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			For State Registrar	State of Mai		artment of F			giene 05	35950
	Physici	an	Decedent's Name (First, Middle, La. Helene T. Bro	st) kus				2. Date of Dea Month	Day Yea	
	/Medic Examin		4a. Facility Name (If not institution, give				r Location of Dear		4c. County of De	
			415 Bowleys Quart 5. Social Security Number 6. S		(In yrs, last birthday)	M1dd.	le River			timore Birthplace (State or Foreign
Н	Funeral Director			□ M 2 🔀 / . Age	88 Yrs.	Months Days	Hours Min		y, Year) 17	Country) MD
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Maryla	tor		N/A	,,	Baltimo	re City			tXXYes 2 ☐ No
	with the 3a or 28e	i Director	10e. Street and Number 1513 E. Clement	Street		10f. Zip Code	2123		10g. Citizen of What USA	Country?
36	72 hours after death with the Maryland natural; or Items 23a or 28e-f ehow dical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ ★idowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ar Black, W Specify:	merican Indian, hite, etc. white
Maryland 21215-0036	be filed within 72 hours after death with the Marylan nial Hygiane. ad other than "natural", or items 23a or 28e-1 show event, tre Medical Examinational be notified at	Completed	15. Decedent's E (Specify only highest gra	de completed) College (1-4or 5+	(Give	dent's Usual Occup kind of work done DO NOT use retired Homemake	during most of wo d)	rking	16b. Kind of Busines Own Hom	
land 2	id be filed v ental Hygie ked other i	To Be Co	17. Father's Name (First, Middle, Last, James Siemek	0		TOTALIBA	18. Mother's Na	me (First, Middle, Kutz	Maiden Sumame)	
Mary	and 2 should be feath and Mental Hin 27 le marked of ter treumatic eve		19a. Informant's Name/Relationship (Barbara M. Snowo						or, City or Town, State	o, Zip Code) r MD 21220
Baltimore,	- F 5 5		20a. Method of Disposition 1 DBurial 2 Cremation 3 C 4 Donation 5 Other (Specif		20b. Place of Disponsion Completery, cred	osition (Name of matory or other place oss cemete	ery 10/	Date 28/2005	20c. Location - City Baltimore	
Balti	permit. Pages 'Depertment of H Important: If ite any injury or of once.		21. Signature of Funeral Sorvice Lice	victor P.	- Ur	2. Name and Addressarles L. 501 East 1	Stevens	Funeral	Home, Inc Limore MD	·21230
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused to one cause on each line	he death. Do not en	ter the mode of dyir	ng, such as cardia	c or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a arferio	consequence of):	Coronar	yartery	desease		
Н	Examiner		Conventingly (internal divine	b.	consequence oi):	/	/			
Н	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		consequence of):					
,8760,	cate be executed physician and the burial-transit	al Examine	that initiated events resulting in death) Last	cDue to (or as a	consequence of):					
687	ficate phys s the	edical		d						
.O. Box	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	Fetal death 3	∃Ectopic pregnancy ☐ Other (specify)	4		23d. Date of o Month	delivery Day Year
a	luires that t n signed by lid be detai	by	Part II. Other significant conditions of	contributing to death but	not resulting in the u	Inderlying cause giv	ven in Part I.			to the cause of death? Probably 4 Marknown
Records,	The law require ste has been signage 2 should b	Completed						24a. Was autop perior 1 \(\text{Yes}	rmed? prior t	autopsy findings available o completion of cause of ? es 2 \sum No
ita	i cie n: Th certificete rector, pag	Be	25. Was case referred to medical examiner?					ath (Check only o		
of Vital	Physi this o	2	1 ☐ Yes 2 ☐ No	Hospital:		II 3 DOA		T	dence 6 Other (Si	pecify)
	ung fred fred fred fred	tion	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day	Year) Injury	Wor	rk? Yes 2 No	Zod. Describe i	low injury occurred	
Division	ol or Atter after dea i Director d in by the	Certification;	3 Suicide 6 Could not be determined		y - At home, farm, st (Specify)	reet, factory, office		28f. Location (S City or Tou	Street and Number or vn, State)	Rural Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical C		nysician: To the best of miner: On the basis of e and manner state	examination and/or in					
	To ti To ti	W	29b. Signature and title of certifier	1 1 1		29c. Licens			29d. Date signed (Mo	
•	17		30. Name and address of person who			Print)	1 Van	Lovsky	44.5	
		10	31. Date filed (Month, Day, Year)	32. Pagistrar	7 - New 2/2 's Signature	-36 /	n. Kewa	cousing	M.S	
	Sta Registi		NOV 0 8 2	200	W. K.	15				

		•	For State Registrar	State of M	Marylan		artmen <i>tificate</i>			and M		giene Reg. No.	2000	35951
	Physici	an	Decedent's Name (First, Middle, Last NORMA)		RD	ANSKY				2. Date of De. Month NOVEMB		, 2005	3. Time of Death 4:26 P M
*	/Medio Examin		4a. Facility Name (If not institution, give	street and number	er)	וטו			Location of	ol Death	HOVEHID		County of Death	1.20
	LAdiiii	CI	544 WOODSIDE RO)AD					BAI	LTIMO			BAL	TIMORE
	Funeral Director		217-14-0430	× 7.		last birthday) 6 Yrs.	If Under Months	1 Year Days	Il Under Hours	24 Hrs. Min.	8. Date of Bird	r 919	9. Birth Cou	nplace (State or Foreign untry) MD
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Maryl f sho	ē	MD BAL	TIMORE		BAI	TIMOR	E						1 ☐ Yes 2 No
	r 28a	Director	10e. Street and Number	127.01.			10f. Zip					10g. Cit	izen of What Cou	untry?
	th with	ai D	544 WOODSIDE RO	AD					212	208				USA
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelih and Mental Hygiene. Importent: If Item 27 is marked other then "naturel", or Items 23a or 28s-f show simply or other treumatic event, the Madical Erain, art must be mutilled at once.	by Funeral	11. Marital Status 1 Mover Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date:	s? X No	· ·	Was Deced f Yes, spec		spanic Ori n, Mexican Specify:	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)		 Race - Amer Black, White Specify: 	
Ö	hour	ed b	15. Decedent's Edu		5.	16a. Dece	dent's Usua	al Occupa	ation			16b. Ki	ind of Business/I	ndustry
15	n "na	Completed	(Specify only highest grad Elementary/Secondary (0-12)		or 5±)	(Giva	kind of woi DO NOT us	rk done a	lurina mosi	t of worki	ng			,
212	d with	E	12	College (1-40	,, J+,	BAN	K TEL	LER				BA	NKING	
Maryland 21215-0036	2 should be filed withir and Mental Hygiene. Ie marked other then eumatic event, the Me	To Be (17. Father's Name (First, Middle, Last) HARRY			BRA	NSKY			r's Name	(First, Middle,	Maiden	Sumame)	BRANSKY
lan	and formal		19a. Informant's Name/Relationship (T)									-	r Town, State, Z	ip Code)
	1 and Heelth em 27 ither tr		MARILYN SOLOMON	/ COUSI		227			VENUE		BAYSIDE		11364 ocation - City or 1	Town State
or or	Pages 1 nent of H nnt: If Ite iry or ot		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F		10	cemetery, crer	natory or o	ther place					ALTIMORE	
	permit. Pag Department Importent: I eny Injury c		4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service License		BAL	TIMORE	ΠΕDΚ . Name an						BROS	
Ba	Departi Departi Importi eny Inj		> Jay Chay	ا										, MD 21208
			23a. Part1/Enter the disease, or como shock, or heart failure. List only o	lications that caus ne cause on each	ed the deat	h. Do not ent	er the mod	e ol dying	g, such as	cardiac d	or respiratory ai	rest,		Approximate Interval Between Onset and Death
<u>ر</u>	Physician		Immediate Cause (Final disease or condition	Arterio	sclena	tic (as	diou	asc	ular	Di	Seaso			Zoyeans
	/Medical Examiner		resulting in death)	Due to (or	as a conseq	ruence of):								,
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a conseq	uence ol):								-
6	uted d ansit	Examiner	Cause (Disease or injury	_										
o o	exectan end	Еха	resulting in death) Last	Due to (or	as a conseq	juence ol):								
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9 ×	entifica fing pl	Med	IF FEMALE:	120 Hung gutoer						-				
Вох	thet the death certific ed by the attending p detached for use as	lan/	in the past 12 months?	23c. If yes, outcor 1□Live birth 4□Pregnant	2 Feta	ıl death 3 [Ectopic pr					1	23d. Date of deli- Month	very Day Year
P.O.	y the d	iysic	1 Yes 2 No 9 Unknown	9☐ Unknowr		Jean 30	J Oli lei (ap	ocny)						
۵.	s thet	by Pr	Part II. Dther significant conditions co	ntributing to death	n but not res	ulting in the u	nderlying c	ause give	en in Part I.		23e. Did te	obacco u	ise contribute to	the cause of death?
rds	w requires to been signer should be										101	es 2	□No 3□Pro	bably 4 Unknown
900	law re as bee 2 sho	Completed									24a. Was autop	an	24b. Were aut	opsy findings available ompletion of cause of
ž	The lav	ĕ									perfo 1 ☐ Yes	rmed? 2 No	death?	2 No
/ita	Physician: r this certifice ral director,	Be (25. Was case referred to medical examiner?							of Death	(Check only o	ne)		
J	Physic this c	၉	1 Yes 2 No 27. Manner ol Death	Hospital: 1 ☐ Inpa 28a. Date of I		ER/Outpatier 28b. Time of			4 🗆 190	rsing Ho	me 5 Resident		6 Other (Spec	ify)
n	ding f	tion	1. Natural 5 ☐ Pending	(Month,	Day Year)	Injury	M	8c. Injury Work	rat ? Yes 2 □		zou. Describe i	iow injui	y occurred	
Division of Vital Records,	Attend death octor; by the	fical	3 Suicide 6 Could not be	28e. Place of	Injury - At h	ome, larm, str								ral Route Number,
á	tal or A	Certification:	4 ☐ Homicide	building,	etc. (Specia	(y) 					City or Tov	vn, State)	
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funerel Director; After this certificete ha completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam		of examina									
	To the within To the comple	Me	29b. Signature and title of certifier		1		290	. License	number			29d. Dat	te signed (Month	, Day, Year)
	4		1 Hiteratello M	De De	puti	1	1	18	666	7		Var	om bo	4.2005
	1	-	30. Name and address of person who c	ompleted cause of	death (Iter	23a) (Type,	Print)		~ w	11	11		1 1	1093
	•		Philip Mil: tell	O,MD	6 Tr	imple	e H: I	10	T. Lu	then	ville, M	ary	land 2	1093
	Sta Regist		31. Date filed (Month, Day, Year)		strar's Signa	k A	and s	7			•	•		

				State of Maryland / Department of Health and Certificate of Death	Reg	2000	35952
	* 2	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death 3:00 PM
4		/Medic	cal	Santina Condon 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of De	November	7 2005 4c. County of Deat	
		Examir	ner	ST. Agnes Hospital Baltimore		,,	
	'Šc	Funeral Director	(B) 11 P	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H Months Days Hours M	rs. 8. Date of Birth	^{9. Bin} 1921 Ma	thplace (State or Foreign buntry) assachusetts
0		pug *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
N		tiled within 72 hours after deeth with the Maryland Hygiene tither than "neturel", or Items 23a or 28a-1 ehow ith, the Medical Examinar must be motified at	ō	Maryland Baltimore Catonsville			1 ☐ Yes 2 X No
11/2/05		r 28a-	Funeral Director	10e. Street and Number 10f. Zip Code	10g	. Citizen of What Co	ountry?
7		th with	aD	2 Summit Hill Court, Apt. B-4 21228		USA	
=		after deeth w or Items 23s	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whit	
	36	s afte	by Fu	1 Never Married 2 Married 1 Yes 2 No 1941 1 Yes 2 No Specify: 1 Yes 2 No Specify: 1 Yes 2 No Specify:		Specify: Wh	ite
5	21215-0036	72 hours "neturel",	ted	15. Decedent's Education 16a. Decedent's Usual Occupation	16	6b. Kind of Business	/Industry
ondon	215	within 73 ene. than "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of with the DO NOT use retired)			
71	2	e filed withing Hygiene.	Con	5+ Nurse		Healthcar	·e
60	Maryland		Be		lame <i>(First, Middle, Ma</i>		
0	Ž	2 should be and Mental le marked raumatic ev	0	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	eppina Laut Rural Route Number, C		Zip Code)
	S S	1 and 2 s Health ar tem 27 le		Margaret E. Condon, Daughter 21 Dungarrie Road Car	tonsville,	Maryland	21228
(3)	_ē,	of Heal		20a. Method of Disposition 20b. Place of Disposition (Name of		c. Location - City or	
Z.	Ē	Pages ment of ant: If It ury or o				altimore,	Maryland
Sandy	Baltimor	permit. Pages Department of H Important: If Ite eny Injury or of		21. Signature of Funeral Services Consessor MacNabb Funeral I George E. MacNabb 301 Frederick Roa	ad Baltimor		nd 21228
		Physician /Medical Examiner	er	resulting in death) Due to (or as a consequence of):	CEK	,	Approximate Interval Between Onset and Death S
	68760,	Hospital or Attending Physician: The law requires that the deeth certificate be executed 24 hours after death. Funeral Director: After this certificate hes been signed by the attending physicien and telly filled in by the funeral director, page 2 should be detached for use as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): d.			
	P.O. Box 6	that the deeth certifi ed by the attending I detached for use as	Physiclan/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of de Month	livery Day Year
		v requires that been signed b should be deta	b	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			o the cause of death?
	Division of Vital Records,	i: The law rec cate hes bee ; page 2 shor	Completed		24a. Was an autopsy performe	24b. Were as prior to death?	utopsy findings available completion of cause of
	ita	ysician: is certifica director, p	Be C	25. Was case referred to medical examiner?	Death (Check only one)		
	∑ <	Physic this ce al dire	မှ	1 Yes 2 No Hospital: 1 hpatient 2 ER/Outpatient 3 DOA Comer: 4 Nursin	g Home 5 Residence		ocify)
	n c	ding Ph h. After th funeral	ion	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 1 No Specification investigation	28d. Describe how	injury occurred	
	isic	death. ctor: A y the fu	ficat	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office		et and Number or R	ural Route Number,
	$\frac{1}{2}$	a after	Certification;	4 ☐ Homicide determined building, etc. (Specify)	City or Town,	State)	
		To the Hospital or Attenwithin 24 hours after deat To the Funeral Director:	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place of the control of the basis of examination and/or investigation, in my opinion, death or and manner stated.	ace, and due to the cau courred at the time, date	se(s) and manner as and place, and du	s stated. e to the cause(s)
_		To th withir To th comp	Me	29b. Signature and title of certifies 29c. License number	7	Date signed (Mont	th. Day, Year)
				+ Kuple- Johnshy WD D1858		NOV t	2005
Y	4	4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VAUL- GORM CBY GOD ATON AVE (BALTIMI	rs Mi	21229
1	4	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature			

Physician //Medical Examiner 1. Decedent's Name (First, Middle, Last) YEVETTE SMITH HILL CALDWELL 4a. Facility Name (If not institution, give street and number) Ab. City, Town, or Location of Death PATTIMORE	Day Year
4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	
Examiner	
ST AGNES HOSPITAL BALTIMORE	N/A
The Way to be to the fact of t	Day, Year) Country)
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
10a. State 10b. County 10c. City, Town or Location	1⊠Yes 2□No
MARYLAND N/A BALTIMORE 10e. Street and Number 10e. Street and Number 10h. Zip Code 40 N. BERNICE AVENUE 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	10g. Citizen of What Country?
40 N. BERNICE AVENUE 21229	U.S.A.
40 N. BERNICE AVENUE 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 (XNo) 1 Never Married 2 Married 1 Yes 2 (XNo)	No- 14. Race - American Indian, Black, White, etc.
9	Specify: BLACK
1 Yes 2 No Specify: 1 Yes 2 No S	16b. Kind of Business/Industry
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) 12th grade 6 yrs SOCIAL WORKER	
12 th grade 6 yrs SOCIAL WORKER 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	DEPT OF SOCIAL SERV.
THOMAS SMITH 18. Mother's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	,
Thomas Smith Thomas Thomas Thomas Thomas Thomas Thomas Thomas Thomas Thomas Thomas Thomas Thomas Thomas Thomas Thomas Thomas Thomas Thomas Th	
≥ 2 € 5 Shantonia Hill/Daughter 1306 Dartmouth Ave. 5 5 1 tive	re. Maryland 21234
Shantonia Hill/Daughter 20a. Method of Disposition 20a. Method of Disposition 1	20c. Location - City or Town, State
Cemetery, crematory or other place Cemetery, crematory or other place	BALTIMORE, MARYLAND
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Fundal Source Licensee 20b. Place of Disposition (Name of cemetery, crematory or other place) DRUID RIDGE CEMETERY 11-09-05 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY 1206 W NORTH AVENUE	FUNERAL HOME P.A.
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory enock, or heart failure. List only one cause on each line.	/ arrest, Approximate Interval Between Onset and Death
Physician Immediate Cause (Final disease or condition resulting in death) American Immediate Cause (Final disease or condition resulting in death)	2 weeks
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Sequentially list conditions, if any, leading to immudiate Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	
a ate a ate	
IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery
M = 25	Month Day Year
9 Unknown 9 Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	d tobacco use contribute to the cause of death?
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. D Coronary artery disease Diabetes 24a. W au 24a. W	Yes 2 No 3 Probably 4 Donknown
Con State Diche Les	as an 24b. Were autopsy findings available prior to completion of cause of
With the second of the second	vformed? death?
25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other: 4 Nursing Home 5 B	
25. Was case referred to medical 26. Place of Death Check on Other: 4 Nursing Home 5 R	esidence 6 Other (Specify)
1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 R 27. Manner of Death 28a. Date of Injury 4 North, Day Year) 28b. Time of Injury 4 Work? 28d. Descrit	e how injury occurred
The state of the s	(Street and Number or Rural Route Number,
28d. Descrit 28d.	Tòwn, State)
25. Was case referred to medical examiner? 1 Yes 2 No No 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death No 1 Natural Natural Natural Natural No 28a. Date of Injury Natural No 28b. Time of Injury Natural Natur	
29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	November 4 2005
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
I I SAUN E PEED MO 900 CATON AVE BALTIM	10RE, MO2/229
State Registrar 31. Date filed (Month, Day, Year) 8 2005 Registrar's Signature	,

			1 - State Amend Items#1	State of Maryland / DOF & 19b per FH (epartment of Health an 349 11 /08 /05 CC Certificate of Death	d Mental Hygie	2°005	35954
	Physic /Medi		1. Decedent's Name (First, Middle, Last	"Cunningham	١-	2. Date of Death	Day Dear	3. Time of Death
	Funeral Director		5. Social Security Number 6. Se 218-46-7317	2 N+e 7. Age (In yrs, last birt	4b. City, Town, or Location of D 10 U SO hday) If Under 1 Year If Under 24 Months Days Hours M		PAUT M 9. Birth PAUT M 9. Birth Control PAUT M P	OPF Inplace (State or Foreign Introduction)
	death with the Maryland ms 23a or 28a-f ehow minat be trotified at	ctor	Usual Residence of Decedent 10a. State 10b. County Hartor	10c. City, Town	Pel Air		/	10d. Inside City Limits 1 ☐ Yes 2 No
	th with th	Funeral Director	10e. Street and Number 205 Kings Cr	ossina Cir. Uni	101. Zip Code	10g.	Citizen of What Cou	untry?
	036 ours after dea real; or items	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Amer Black, White Specify:	
	Maryland 21215-0036 at 2 should be filed within 72 hours after the and Mental Hygiene. 27 Is marked other then "natural", or its traumatic event, the Madical Examina	Completed	15. Decedent's Edu (Specify only highest grad		Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	working 16t	b. Kind of Business/li	ndustry \(\sqrt{\lambda} \sqrt{\lambda} \)
	yland 2 buid be filed Mental Hyg arked other	To Be C	17. Father's Name (First, Middle, Last)	ephins		Name (First, Middle, Mail	den Sumame)	Julen - 1
50	- m		20a. Method of Disposition	ham, III 20b. Place of	Mailing Address (Street and Number of Disposition (Name of y, crematory or other place)	a Cir. Unit	ity or Town, State, Zi	ic M 21012
16/1	Baltimore, permit. Pages 1 a Department of Hei Important: If Item eny injury or othe once.		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	Beltin	Nemerial Gardens 1		HILL, MD.	
•	Physician /Medical Examiner		23a. Part1. Enter the disease or compishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ilitations that caused the death. Do not cause on each line. a	im concer	diac or respiratory arrest,	hr, 3New	Approximate Interval Between Onset and Death
12 30	cate be executed physicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b				
ancy	Records, P.O. Box 68 The law requires that the death certifics lie has been signed by the attending plage 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of deliving Month	very Day Year
5	cords, P w requires that been signed b should be deta	by	Part II. Other significant conditions co.	ntributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobac	2 No 3 Pro	the cause of death?
Z F	Vital Record sician: The law requir certificate has been si	Completed				24a. Was an autopsy performed 1 Yes 2	d? death?	opsy findings available ompletion of cause of
-	on of Vital Reding Physician: The h. After this certificate his truneral director, page	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	patient 3 DOA Other: 4 Nursin	Death Check only one) ng Home 5 Residence	e 6 \(\Delta \) Other (Speci	mHospice
unning	Division of to Attending Patter death. Director: Attert I in by the funera	Certification;	27. Manner of Death 1 ∰Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, far	njury Work? M 1 Tyes 2 No		nt and Number or Rur	al Route Number,
5	Divisir To the Hospital or Attention within 24 hours after death To the Funeral Director:		29a. Certifier 1 💢 Certifying Phy	building, etc. (Specify) sician: To the best of my knowledge,	death occurred at the time, date and p	City or Town, S	e(s) and manner as	stated.
	To the Hospital of within 24 hours at To the Funeral Documbletely filled is	Medical	(Check only 2 Medical Examione) 29b. Signature and title of certifier	iner: On the basis of examination and and manner stated.	29c. License number	29d.	Date signed (Month,	. Day, Year)
	12		30. Name and address of person who ca	ompleted cause of peath (Item 23a) (ventir 7,	2005
	Sta	ate	31. Date filed (Month, Day, Year)	M C N N .	ules it. Balto vnd	2,20		
	Regist	_	NOA 0 8 5002	A2. Registrar's Signature	y			

ORIGINAL

			_ State	State of Maryland / Depa	artment of Health and M rtificate of Death			35955
			Registrar 1. Decedent's Name (First, Middle, Last)		incate of Boats	2. Date of Death		3. Time of Death
	Physici			J.	Curbeam	Month 11	02 200	5 12:35a
>	/Medic Examin		Osie Belle 4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Death		4c. County of Deat	h
	Examin	Ο,	835 Crystal Pa		Owings Mills		Baltimo	re
	Funeral		Social Security Number 6. Sex	u dele	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) Co	hplace (State or Foreign untry)
l.	Director		216-20-5864	M 2√1 F 80 Yrs.		03 30	25	SC
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	Maryl f ehc	ō	MD Baltim	ore Owings	Mills			1 □ Yes 💹 No
	28°	rec	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Co	untry?
	13a ol	Die	835 Crystal Pal	ace Ct.	21117		U.S.A.	
	deet deet	Funeral Director		Was Decedent Ever in U.S. 13. \ Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
õ	or it	E	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No	1 ☐ Yes 2 ▼ No Specify:	,		lack
5-0036	hours after deeth with the Maryland turel', or Iteme 23a or 28e-f ehow al Examiner must be notified at	d by	3 XWidowed 4 □ Divorced		doet's Havel Occupation	1	6b. Kind of Business	
7	within 72 ene. then "nat	lete	15. Decedent's Educ (Specify only highest grade	(Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing '	db. Killd of Business	aldustry
7121	within 72 hours after deeth with the Marylan jiene. Than "naturel; or Iteme 23a or 28e-1 show the Madical Examinar must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 2yrs T	leacher!		School	
	0 2 2 -	BeC	17. Father's Name (First, Middle, Last)		18. Mother's Nam	e (First, Middle, M	faiden Sumame)	
ā	buld be fill Mental H arked oth atto even	ToB	Joe Johnson		Patsy			
Maryland	s 1 and 2 should I I Heelth and Meni Item 27 ie marke other traumatic		19a. Informant's Name/Relationship (Typ	Daughter 19b. Mailir	ng Address (Street and Number or Run	al Route Number,	City or Town, State,	Zip Code)
	and seeith m 27		Olivia Curbeam-	The second secon	Crystal Palace		20c. Location - City or	
altimore,	Pages 1 and neut of Hee Int: If Item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	matory or other place)			
=	t. Partmen tant:		4 Donation 5 Other (Specify)		Memorial 11/ Name and Address of Facility	8/05 A	rbutus,	Ma
Ba	permit. Pages Department of I Important: If it eny injury or o		21. Sign ture of Funeral Service License)	March F/H West	Dole:	more Ma	21215
			23a, Part1. Enter the disease, or compli	cations that caused the death. Do not ent	1300 Wabash Ave ter the mode of dying, such as cardiac			Approximate
			shock, or hear vailure. List only on fmmediate Cause (Final	e cause on each line.				Interval Between Onset and Death
} '	Physician /Medical		disease or condition resulting in death)	Due to (gr as a consequence of):	pochur in	reum		
	Examiner			(monra)	empolism.)		
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):	•			
2	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):	MASCO			
3760,	ate be executed hysicien and the burial-transit	E		Due to (or as a consequence or).				
	death certificate be executed e ettending physicien and nd for use as the burial-transit	dical		l			ř	
9 X	eath certifica ettending ph I for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy			23d. Date of de	livery
Вох	death s etter d for u	ciar	in the past 12 months?	4☐Pregnant at time of death 5☐	☐Ectopic pregnancy ☐ Other (specify)		Month	Day Year
O.	at the de by the or tached	hys	9 🗆 Unknown	9□ Unknown		-		
o.	res tha	by P	Part II. Other significant conditions cor	ntributing to death but not resulting in the u	inderlying cause given in Part I.		acco use contribute to	
ğ	w require been sig should b		Cotrovat	prais , surve	/	1 □ Ye	s 2∐No 3∏P	robably 4 Unknown
Records,	2 8 S	pie				24a. Was ar autopsy	24b. Were a	utopsy findings available completion of cause of
		Completed				perform 1 ☐ Yes 2		2 □ No
<u>ita</u>	iclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:	Other	th (Check only one		
Division of Vital	두 등등	70	1 Yes 2 N6	1 ☐ Inpatient 2 ☐ ER/Outpatier 28a. Date of Injury 28b. Time o	nt 30 DOX 40 Nulsing H	ome 5 H side 28d. Describe ho	nce 6 Other (Spe	cify)
G	ding h. After fune	ţ	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury	of 28c. Injury at Work? M 1 Yes 2 No		,,	
/ISI	Attending Physician: r death. ector: After this certific by the funeral director.	fica	3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, str	reet, factory, office	28f. Location (Str	reet and Number or R	ural Route Number,
á	al or A s efter il Direct	Certification:	4 Homicide	building, etc. (Specify)		City or Town	, State)	
	To the Hospital or Attending F within 24 hours efter death. To the Funerel Director: After completely filled in by the funer			sician: To the best of my knowledge, deat nar: On the basis of examination and/or in				
	the H tin 24 the F.	Medical	one)	and manner stated.				
	or Too	Σ	29b. Signature and title of certifier	X	29c. License number	25	9d. Date signed (Mon	11, way, 10d1/
	7		Chion (2) ()	D/117/		11/7/0	5
	10		30. Name and address of person who co	impleted cause of death (ftem 23a) (Type.	Fre 509	POR		
	St	ate	31. Date filed (Month, Day, Year)	32 Aegistrar's Signature	2 10			
	Regist		NOV 0 8 20	15 Bear St Ap	WILL!			

COLEMAN

	1-	For State Registrar		Sta	ite of M	larylan	d / Depa	artmen <i>tificat</i>	t of H	ealth a Death	and M	ientai H	/giene Reg. No		5 3	359	57
Physician	1. De	ecedent's Name		,								2. Date of D Month	Da	у	'ear	3. Time of	
/Medical	40.5	Facility Name (If	laxine		llier-		3	45 0%	T		-1 D11	Nove		4, 2		7:15	A M
Examiner		211 28tł		_	and number)	,			Rain	Location	of Death			. County of		-1 - c	
Funeral	5. Sc	ocial Security Nu	mber	6. Sex	7. A	ge (In yrs.	last birthday)	If Under	1 Year	If Under		8. Date of B		rince	. Birthpla	ce (State or	
Director	-	78–70–84		1 □ M 2	₽ F	52	Yrs.	Months	Days	Hours	Min.	8. Date of B (Month, D 12-31-	1952	Wa	ashir	ngton,	, DC
and		al Residence of State	10b. County	-	·	10c. Cit	y, Town or Lo	cation				<u> </u>			100	d. Inside Cit	v Limits
the Marylar 286-f show nulling at	P	(ID	Prince	Georg	ge's		Raine									1 Yes	•
r 286	10e.	Street and Num	ber			.1		10f. Zip	Code				10g. Ci	tizen of Wh	at Countr	y?	
5-0036 72 hours after death with the Maryland nature!; or Items 23a or 28e-1 show dical Examinar must be notified at each earth and Examinar must be notified at each of Europe and Director		4211 28	th str	eet				20	0712				U:	nited	Stat	tes	
tems srm	11. 1	Marital Status	- 2	An	as Decedent med Forces	?	.S. 13.	Was Deced	dent of His cify Cubar	spanic Ori n, Mexicar	igin? (Spe n, Puerto	ecify Yes or N Rican, etc.)	lo-	14. Race - Black,	American White, et		
rs after II, or I		l □ Never Marrie 3 □ Widowed 4		lf ']Yes 2∰ ∕es, Give ar or Dates:			1 □ Yes	2 No	Specify:				Specify B	lack		
21215-0036 ed within 72 hours all ygiene ygiene the "haturel", or t, the Medical Exami t, the Medical Exami			15. Decedent	s Education			16a. Dece	dent's Usua	al Occupa	ition			16b. K	(ind of Busin		stry	
thin 7	EI	(Special Special fy only highesi Idary (0-12)		oleted) illege (1-4or	5+)	(Give	kind of wo DO NOT u	rk done d se retired)	luring mos)	t of worki	ng				·		
21 ed wi ygien ygien f, the				1			Medic	a1 1	B ill i					rivate			
and the fill and the ed out		Father's Name (i James ((First, Middl Mae Wi	.,	,			
Maryland to 2 should be file th and Mental Hy 77 Is marked oth traumatic event To Be (. Informant's Na	me/Relationsh	ip (Tvoa. Pr	int)		19b Mailir	na Address	(Street a			l Route Num			ate Zin (odel	
Ma nd 2 s uith ar 17 is r trau		Ronald D		(Spous	•		4211					ner, M			116, 270 0	000/	
othe		Method of Disp					Place of Dispo cemetery, crer	sition (Nar	ne of	a)	D	ate	20c. L	ocation - Ci	ty or Tow	n, State	
Page nent cant. If ant: If ary or		1 ☐ Burial 2 ☐ 4 ☐ Donation			al from State	Ft.	Linco	1n C	emete	ry	11/7	/2005	Bre	ntwood	1, MI)	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. To hours after death with the Maryla Is marked other then "nature!, or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examinar must be initial at once. To Be Completed by Funeral Director	21.	Signature of Fur	negal Service L	homo) <u> </u>	<i>r</i> _					1	Linco d Bre					
E 1980	23a	. Part1. E th shock, or hear	e disease, r o			ed the death									A	Approximate nterval Betv	
Physician	dise	nediate Cause (I ease or condition	Final		Ovaria											Onset and D	
/Medical Examiner	rest	ulting in death)		(a	Due to (or as	s a conseq	uence of):								_		
- Zaminei	Seq	uentially list con	ditions,	b	Due to (or as										_		
	Cau	se. Enter Unider	niury -	-	Due to (or as	s a conseq	derice or):										
o, cexecuted an and rial-transit	resu	initiated events ulting in death) L		c	Due to (or as	s a conseq	uence of):										
cate be executed physician and it the burial-transit clical Examir				d													
rtifica ng ph as the	le e	EMALE:						-					-				_
Box 6 death certifi e attending d for use as Iclan/Me	23b	. Was decedent in the past 12 i		10	yes, outcome ⊒Live birth	2 Feta	I death 3	Ectopic pr						23d. Date of	,		'ear
		1 ☐ Yes 2 ☐ 9 ☐ Unknown			□Pregnant a □Unknown	at time of d	leath 5	Other (sp	ecify)					Month		ay i	oui
ords, P.O requires that the een signed by the rould be detached by the red by Physical By	Part	II. Other signifi	cant condition	ns contributi	ng to death l	but not res	ulting in the u	nderlying c	ause give	n in Part I		23e. Did	tobacco	use contribu	ute to the	cause of dr	eath?
									-			1 🗆	Yes 2	⊒No 3	☐ Probat	oly 4 🔲 U	inknown
law requires as been so a should pleted	-											24a. Wa	s an	24b. We	re autops	sy findings a	available
I Record The law requirements that has been spage 2 should												auto per 1 ☐ Yes	opsy formed? 2 % No	prio	or to comp ath?]Yes 2	pletion of ca	iuse of
Vital Fraicien: The secrificate director, pag	25.	Was case referr	ed to medical							26. Place	of Death	(Check only		, , , ,	1163 2	- 140	
hys hys		1 Yes 2		Hospita	1 U Inpati		ER/Outpatier	t 3 🗆 DC	Othe	or: 4 □ Nu	rsing Hor	me 5 th Res	sidence	6 Other	(Specify)		
In the Ind	27. !	Manner of Death 1 🕏 Natural	5 Pending		a. Date of Injude (Month, Da	ury a <i>y Year)</i>	28b. Time of Injury		8c. Injury Work			28d. Describe	how inju	ry occurred			
Division tor Attending after death. Director: After in by the tune		2 Accident 3 Suicide	investig 6 ☐ Could n	ot be	Place of In	niury - At ho	ome, farm, str	M not factor		/es 2 □		28f. Location	/Stroot o	nd Mumbar	or Pum/	Dauea Alumi	ho-
Division c ppitel or Attending P ours after death revel Director: After t filled in by the funera at Certification:		4 🗌 Homicide	determi	ned 200	building, e	tc. (Specify	y)	eet, lactory	y, onice		- 1	City or To	wп, State	9)	or murai r	noute ivains	767,
<u>a</u> ∃ ≡		. Certifier	1 Certifying	Physician	: To the best	t of my kno	wledge, deatl	occurred	at the tim	e, date an	id place, a	and due to the	e cause(s	and mann	er as stat	led.	
To the Hosp within 24 hou to the Fune completely fill		(Check only one)	2 Medical E	xaminer: ()	n the basis of nd manner s	of examina tated.	ition and/or in	vestigation	, in my op	inion, dea	ith occurre	ed at the time	, date an	d place, and	1 due to th	ne cause(s)	
To t To t com	29b	. Signature and	title of certifier						. License					te signed (#		ay, Year)	
		* *	1000	Co	e				591	L42			11	1/4/20	105		
12		Name and addre Charles							2114 + ~	205	64.	lver S	nri-	, MD	2000	12	
State	_	Date filed /Mont	h Day Year)		32 Pagiet	trar's Signa	gia Ay	34	JUILE	- 200	31.	rver 9	hr TII8	5, FID	2090		
Registrar			OVO 8	2005	32 Aegist	Alice of											

			For State Registrar	State of	f Maryland		artment of H			giene () ()5	359	58
	* 3 %	£**	1. Decedent's Name (First, Middle, La.	st)					2. Date of Dea Month	ith	Vara	3. Time o	f Death
	Physici /Medic		Zula Virginia C	ross						er 6, 2	005	9:30	АМ
Н	Examin		4a. Facility Name (If not institution, give				4b. City, Town, or			4c. County			
			Ivy Hall Geriatri			- 16 (-1-1-1-1	Middle R	liver			imore		
	Funeral Director		5. Social Security Number 6. S 214–36–2143	ex □M XX F	7. Age (In yrs. I	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Dec. 28	, 1923	9. Birthp Cour West	olace (State ontry) Virg	or Foreign inia
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	cation					IOd. Inside C	
	Aaryli r sho	ั้	Maryland Baltimor	·e		dle Ri							2 X No
	28a-	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cour	ntry?	
	3a or		103 Yawmeter Driv	7 <u>0</u>			2122	20		U.S.		,	
	ms 2	nera	11. Marital Status	12. Was Dece	edent Ever in U.	S. 13.	Was Decedent of His f Yes, specify Cubai		ecify Yes or No-	14. Rac	e - Americ		
36	within 72 hours after death with the Maryland ane. then "natural", or Items 23a or 28a-f ehow ta Madigal Examinar maat be notitied at	by Funeral	1 ☐ Never Married 2 ☐ Married	Armed Fo 1 ☐ Yes If Yes, Giv	2 ∑ No ′e		r yes, specify Cubai 1 □ Yes 2 🛭 No	Specify:	Rican, etc.)	Specif	ck, White,		
8	tural	ed t	15. Decedent's Ed	Year or Da	ates:	16a Decer	dent's Usual Occupa	tion		16b. Kind of B	Whi		
15	n na	plet	(Specify only highest gra	de completed)	45-)	(Give	kind of work done d DO NOT use retired)	uring most of work	ing	100. Killa 01 B	m21119273111	Justry	
21215-0036	d with giene	Completed	Elementary/Secondary (0-12)	College (1	-40r 5+)	Assen	bler			Electr	onics	Manu	fact.
밀	al Hy al Hy other	Be	17. Father's Name (First, Middle, Last,					18. Mother's Name		Maiden Suman	ne)		
Maryland	d Ment d Ment marked matic e	10	Laten Marshall G			10h Madie	ng Address (Street a	Gladys B		- C'+ T	Ota 1 - 7:-	0-4-1	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show with injury or other traumatic event, the Medical Examination in a notice.		Diane Peyton (Day				Emily Dri						
Baltimore,	of He of He If Item or othe		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐	Removal from		ace of Dispo	sition (Name of natory or other place	,)	Date	20c. Location	-		
ij	Pag tment tant:		4 □ Donation 5 □ Other (Specification)	y)	Hol		.1 Mem. Ga		0,2005	Baltim	ore,	Maryla	and
Bal	Depar Depar Impor eny In		21 Signature ALT unioral STAVICA LICA				Name and Addres. Bri 407 Old	ızdzinski					1221
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cone cause on e	aused the death ach line.	. Do not ent	er the mode of dying	, such as cardiac o	or respiratory ar	rest,		Approximation and Interval Better	te tween
	Physician		tmmediate Cause (Final disease or condition	a	Meto	Na.	tic 15	Vania	in C	on c	0	Onset and	Death
•	/Medical Examiner		resulting in death)	Due to (or as a consequ	ience of):							
		Jer	Suquentially list conditions if any, leading to immediate	b. Due to (or as a consequ	ience of):					-		
	ocuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C									
8760,	cate be executed physician and the burial-transit	al Ex	resulting in death) Last	Due to (or as a consequ	ience of):							
587	icate phys s the	edical		d									
Box (death certiff e attending id for use as	Z/M	IF FEMALE: 23b. Was decedent pregnant		come of pregna					23d. Da	ite of delive	ery	
O. B	that the death cert ed by the attendin detached for use	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		irth 2 ☐ Fetal ant at time of de own		Ectopic pregnancy Other (specify)				onth	-	Year
Q.	res that th igned by be detach	/ Phy	Part II. Other significant conditions of			ilting in the u	nderlying cause give	n in Part I.	23e. Did to	bacco use con	tribute to th	ne cause of	death?
Division of Vital Records,	The law requires that the to be as been signed by the bas been signed by the bage 2 should be detache	ed by							1 🗆 Y	es 2.2 No	3 ☐ Prob	oably 4	Unknown
ecc	e law re has be je 2 sho	Completed							24a. Was autop	an 24b.	Were auto	psy findings mpletion of c	available cause of
H		Ş							perfor		death? 1 🗌 Yes	2□ No	
Vita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:			10%	26. Place of Death	h Check only o	ne)			
of	Phys this rat di	2	1 Yes 2 No 27. Manner of Death	28a. Date		ER/Outpatier 28b. Time of		4 Hursing Ho	me 5 Resid			y)	
O	ding Ph th. After thi funeral	ton	1 Natural 5 Pending 2 Accident investigation	(Mont	th, Day Year)	Injury	Work	? 'es 2 🗆 No	28d. Describe h	ow injury occur	190		
Visi	Attending or death. ector; After by the fune	Iffica	3 Suicide 6 Could not b	e 28e. Place	of Injury - At ho	me, farm, str	eet, factory, office	-	28f. Location (S		ber or Rura	I Route Nun	nber,
Ö	Ital or irs afte ral Dir led in l	Certification:			ng, etc. (Specify				City or Tow				
	To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the ft	edical	29a. Certifier 1 Certifying Pt (Check only 2 Medical Examone)	mmer: On the ba	asis of examinat ner stated.	wedge, death ion and/or in	vestigation, in my op	e, date and place, inion, death occurr	and due to the cred at the time, o	ause(s) and midate and place,	anner as si and due to	ated. the cause(s)
	with To t	Σ	29b. Signature and title of certifier	0 h	, <i>t</i>) ~	29c. License			29d. Date signe	ed (Month,	Day, Year)	
,	ĺ		•	XX	_ 1), O,	H	3556	13 1	Nov.	1. 2	-005	>
	*		30. Name and address of person who	complied us	e of death (Item	23a) (Type,	Print) H ace A	ng B	altim	ore i	MD	2 12	21
4.	Sta		31. Date filed (Month, Day, Year)	32. R	egistrar's Signat	ture		1)	E-P-	<u> </u>	-/
	Regist	ar	NOV 0 8 2005	20,0	J.	Anort	E Comment						

DHMH 17 Rev 1/200

Registrar

PRAUCIS

		1 - For Stata Ragistrar	State of Maryla		rtificate of		and M	Re	9. No. U U	5	35960
Physic		Decedent's Name (First, Middle, Last) Cathy Ann Ca	nnon					2. Date of Death Month 10/20		Year	3. Time of Death 10:20Ant
/Medi Examîi		4a. Facility Name (If not institution, give s			4b. City, Town,		4c. County of Death				
		Upper Chesapeake M	- , 	to a file to the state of	If Under 1 Year	elair	24 Ыго			Harf	
Funeral Director		5. Social Security Number 438–98–4044 6. Sex	M 2 → F 54	s. last birthday) Yrs.	Months Days		Min.	8. Date of Birth 01/09/1	951	9. Birthi	place (State or Foreigntry) LA
Maryland a-f show	ctor	10a. State 10b. County 10b. County Jeffe	rson 10c. C	City, Town or Lo	Meta	irie					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
th with the 23s or 28	ai Director	10e. Street and Number 5220 Utica Street			10f. Zip Code 70006			10	g. Citizen of W USA		ntry?
be filed within 72 hours after death with the Maryland trial Hygiene. Ind other than "netural", or Items 23s or 28s-f show event, the Madical Examiner must be notified at	by Funerai	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 2 4 0 If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cub 1 ☐ Yes 2XXXNo		gin? (Spi i, Puerto	ecify Yes or No- Rican, etc.)		k, White,	can Indian, etc. White
n netu	Completed	15. Decedent's Edu (Specify only highest grade	completed)	16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire	pation during mos	t of work	ng 1	6b. Kind of Bu	siness/In	dustry
giene er tha	Com	Elementary/Secondary (0-12) unk.	College (1-4or 5+) unk.		Disable	d			N	/A	
d 2 should be liled within 72 hours at the and Mental Hygiers than "neturel", or traumatic event, the Medical Exem	To Be	17. Father's Name (First, Middle, Last) Krum J. Cannon				18. Mothe		e (First, Middle, N Cetta Bac		e)	
		19a. Informant's Name/Relationship (Ty, James Cannon / Br	other	19b. Maili 3207	ng Address <i>(Str</i> ee East Ben	d Cour	or or Rura	Abingdon	MD 210	State, Zip 09	Code)
Deemit. Pages 1 ar Depertment of Hea Important: If item: any Injury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☑ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State G	ardens	osition (Name of matory or other pla of Memor	ies		26/2005	Metai		
permit. Pag Depertment Importent: I eny Injury o		21. Signature of Funeral Service License	Victor Dod		2. Name and Addr barles I 501 E. F	ess of Facilit Stevent Ort Av	y Yens Yenuc	Funeral Baltin	Home nore MD	Inc 212	30
Fnysician	10	23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)	cations that caused the de- e cause on each line.	ath. Do not en		ng, such as	cardiac o	or respiratory arre	st,		Approximate Interval Between Onsel and Death
ificate be executed g physicien and as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence or):	ramm.	21ory	/ NE	sponse	Synari	20116	5 days
The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Mo 9 □ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	⊒Ectopic pregnand ☐ Other (s <i>pecify)</i> _	y			23d. Date Mor		ery Day Year
quires that n signed b	by	Part II. Other significant conditions cor Cerebral Palsy	tributing to death but not re	esulting in the u	inderlying cause gi	ven in Part I.		23e. Did tob			he cause of death?
	Completed	Seisure dison	ler					24a. Was ar autopsy perform 1 Yes 2	ed/? d	Vere auto rior to co eath? Yes	psy findings available mpletion of cause of 2 \(\square\) No
rsicier s certif	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 v npatient 2[☐ ER/Outpatier	nt 3 DOA Ot	har		Check only one			
Attending Physicien: r death. ector: After this certifica	ition: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Inju			me 5 Resider 28d. Describe hor			y)
는 를 들 드	Certification:	3 Suicide 6 Could not be determined	28e. Ptace of Injury - At building, etc. (Spec	home, farm, st	reet, lactory, office			28f. Location (Str City or Town,	eet and Numbe State)	or Pura	al Route Number,
To the Hospitel or Al within 24 hours after of To the Funerel Direc completely filled in by	edical	29a. Certifier 1 Certifying Physical Chack only 2 Medical Exami	sicien: To the best of my know. To the basis of examinand manner stated.	nowledge, deat nation and/or in	h occurred at the to vestigation, in my	ime, date an opinion, dea	d place, th occurr	and due to the ca ed at the time, da	use(s) and mai te and place, a	nner as s ind due to	tated. o the cause(s)
To the within To the complete	Me	29b. Signature and title of certifier	mp			se number	, 60	7 (d. Date signed	(Month,	Day, Year)
ń	ate	30. Name and address of person who co	MD Su to 20 32 Pegistrar's Sign	05 602	Print)						

Cannon, Cathy

1003

		•	State of Maryland / State Registrer	Department of Health and M Certificate of Death	ental Hygiene 05	35961
-			Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
	Physici /Medic	_	Joseph Carver		October 27 2005	18:55 PM
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Dea	ath
			Mercy Medical Centre 5. Social Security Number 6. Sex 7. Age (In yrs. last b.	Balhinor If Under 1 Year If Under 24 Hrs.	N/A 8. Date of Birth 9. Bir	rthplace (State or Foreign
-8	Funeral Director		213-90-1798 1 2 ₩ ² □ F 37	Yrs. Months Days Hours Min.		ountry) MD
			Usual Residence of Decedent			10d Inside City Limits
	ith the Marylan or 28a-f ehow	ctor	10a. State MD Anne Arundel 10c. City, Tow	Halethorpe		10d. Inside City Limits 1 ☐ Yes 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	h with the	ai Director	10e. Street and Number 3002 Michigan Avenue	10f. Zip Code 21227	10g. Citizen of What C	,
36	172 hours after death with the Maryland "natural", or itema 23a or 28a-f ehow calcal Examinational be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ vivorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼ ▼ Sive Year or Dates:	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes ➤ Yoo Specify:	acity Yes or No- Rican, etc.) 14. Race - Am Black, Wh Specify:	
5-0036	72 hou natura	eted	15. Decedent's Education (Specify only highest grade completed)	a. Decedent's Usual Occupation (Give kind of work done during most of work)	ng 16b. Kind of Business	s/Industry
2121	d within giene. er then	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Firefighter		ic Service
land	2 should be filed within and Mental Hygiene. is marked other then sumatic event, the Ma	To Be (17. Father's Name (First, Middle, Last) Joseph D. Carver, Sr.		(First, Middle, Maiden Sumame) .ce L. Gray	
Maryland	ges 1 and 2 should be filed within 72 hc it of Health and Mental Hygiene. If item 27 is marked other then "nature or other traumatic event, Its Medical			b. Mailing Address (Street and Number or Rura)7 Misty Meadow Lane,	·	Zip Code)
Baltimore,	permit. Pages 1 and 2 Department of Health a Important; if item 27 is any injury or other trea		20a. Method of Disposition 20b. Place camet.		20c. Location - City o	
Baltii	permit. P Departm Importar any inju		21. Signature of Funeral Service Licensee Victor P. Doda	Charles L. Stevens	Funeral Home, Inc	21230
			23a. Part 1. Enter the disease, or compilications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac of	or respiratory arrest,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition a. Respiratory resulting in death)	failure		Onset and Death
34	Examiner		Immediate Cause (Final disease or condition resulting in death) a. Respiratory Due to (or as a consequence Sequentially list conditions,	4 months		
,	P =	ner	if any, leading to immediate Due to (or as a consequence cause. Enter Underlying	9 of):		
/	be executed ician end burial-transit	Examiner	Cause (Disease or injury that initiated events c	a of):		
8760,	ate be ex hysician the buria					
687	ficate p phys is the	edicai	0.			
Box	The law requires that the death certifica te hes been signed by the attending pt hage 2 should be detached for use as it	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat dea! 4 ☐ Pregnant at time of death	th 3 Ectopic pregnancy 5 Other (specify)	23d. Date of di Month	elivery Day Year
P.O.	res that the signed by be detact	by Ph	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco use contribute	to the cause of death?
rds	quires in sign	ed b			1 Ves 2 No 3 F	Probably 4 □Unknown
Division of Vital Records,	The law requir ate hes been si page 2 should	Completed			autopsy prior to death?	autopsy findings available completion of cause of
tal		O O	25. Was case referred to medical	26. Place of Deatl	1 Yes 2 No 1 Yes	35 2 140
<u> </u>	ysicia is cer direc	To B	examiner? 1 Yes 2 No Hospital: 1 Impatient 2 ER/C	Outpatient 3 DOA Other: 4 Nursing Ho	me 5 ☐ Residence 6 ☐ Other (Sp	ecify)
o no	Attending Physician: r death. ector: After this certific by the funeral director,	tlon:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year)		28d. Describe how injury occurred	
Divis	i or Attendi after death. Director: A	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Street and Number or I City or Town, State)	Rural Route Number,
	Hospita 4 hours Funerai	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowled control on the basis of examination and manner stated.	ge, death occurred at the time, date and place, and/or investigation, in my opinion, death occurr	and due to the cause(s) and manner ed at the time, date and place, and di	as stated. ue to the cause(s)
	To the Hos within 24 hr To the Fun completely	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Moi	nth, Day, Year)
			> ga/aym, MD	P17646	Octobe ?	27,2005
	10		30. Name and address of person who completed cause of death (Item 23a Ternife Taylor, Merry Medical Centre		Baltimon, MD 218	101.
9		ate	of Date Stat (Month Day View) 20 Deciments Signature			
	Regist	irar	NOV 0 8 2005	of Goods		

German Castillo 05-7338 AKG

10.0	an	1. Decedent's Name (First, Middle, Last) German Cas	stillo					2. Date of De OCTObe		2005	3. Time of Death 1:55 P
/Medio		4a. Facility Name (If not institution, give str			4b. City, T	own, or Locati	on of Death	00000		County of Dea	
	jaș	1537 Light Street			Baltin						
Funeral Director			M 2 F	yrs. last birthday	y) If Under 1 Months	Days Hou	der 24 Hrs. rs Min.	8. Date of Bir (Month, Da July 16	1948	_ C	thplace (State or Fore ountry) tamala
a-f ehow	ctor	Usual Residence of Decedent 10a. State	100	c. City, Town or Balt	Location imore						10d. Inside City Lim
38 or 28	Funeral Director	10e. Street and Number 1526 Byrd Street			10f. Zip (230				en of What Co	ountry?
Department of Health and Mental Hygiene. important: if Item 23s or 28s-f show important: if Item 27 is marked other then "natural", or Items 23s or 28s-f show eny injury or other treumatic event, the Medical Examinar must be notified at once.	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Morried	2. Was Decedent Ever Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates:	in U.S. 13	3. Was Decede If Yes, specifi 1 Yes 2	y Cuban, Mex	ican, Puerto	ecify Yes or No Rican, etc.)		4. Race - Ame Black, White Specify:	
ygiene. ierthen "natu t, the Medical	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12) 12		(Giv	edent's Usual ve kind of work DO NOT use Baker	Occupation done during n retired)	most of work	ing		of Business aking	/industry
Mental Hy arked oth atic even	To Be	17. Father's Name (First, Middle, Last) Edwardo Castillo)			18. Me	Flor	e (First, Middle es Her	Maiden S rera	u <i>mam</i> e)	
alth and n 27 ie m er treum		19a. Informant's Name/Relationship (Type Maria Cante/Aunt	a, Print)					al Route Numb timore			Zip Code)
nent of He ant: If Iten ury or oth		20a. Method of Disposition 1 □ Burial 2 SCremation 3 □ Rei 4 □ Donation 5 □ Other (Specify)	moval from State	Ob. Place of Disp cemetery, cr Bayview	rematory or oth	er place)	Nov 2005	Date 4,		ation - City or cimore	
Departr Imports eny inju		21. Signature d'Funeral Service Licensee				es L. Sta	acility evens F	uneral H altimore			
e attending physicien and drives as the burial-transit	cal Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Chronic al Due to (or as a cor Chronic al Due to (or as a cor Due to (or as a cor	nsequence of): coholis nsequence of):							
attending for use as	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pro 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	B⊟Ectopic pred				23	d. Date of de Month	livery Day Year
ac t	þ	Part II. Other significant conditions control	ributing to death but no	t resulting in the	underlying cau	use given in Pa	art I.		obacco uso		the cause of death
igned by be detac	6							24a. Was	osy	prior to	utopsy findings availa completion of cause
ete has been sign page 2 should be	e Completed	25. Was case referred to medical				26 0	loop of Death	Yes Yes	2 No	death? Yes	2 □ No
this certificete has been sign al director, page 2 should be	To Be	27. Manner of Death 1 Natural 5 Dending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Yea		of 28	Other: 4 □ c. Injury at Work? 1 □ Yes 2	Nursing Ho	Yes n (Check only of me 5 Resid	2 No one) dence 6x how injury	SOther (Spe	ody) at scen
ffer death. Nrector: Atfer this certificete has been sign in by the funeral director, page 2 should be	Certification: To Be	examiner? 1 XYes 2 No 27. Manner of Death 1 X Natural 5 Pending Investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Yea 28e. Place of Injury - building, etc. (S)	28b. Time Injury At home, farm, specify)	of 28. M street, factory,	Other: 4 C. Injury at Work? 1 Yes 2	Nursing Ho	Yes (Check only of the control of t	2 No one) dence 6x how injury Street and wn, State)	Other (Spe occurred	ural Route Number,
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	1 - State	State of Maryland	Certificate of	Health and Ment <i>Death</i>			35963
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1. Decedent's Name (First, Middle, Las	")	Certificate of	2. Da	Reg. ate of Death		3. Time of Death
Physician /Medical	Edith	Carter		M	NOV (04 85	11157 ам.
Examiner	4a. Facility Name (If not institution, give	street and number)	4b. City. Town, o	or Location of Death		4c. County of Death	
Funeral	5. Social Security Number 6. Se				ate of Birth	9. Birth	place (State or Foreign
Director	240-04-0000	□M 2ÅF 66	Yrs. Months Days		fonth, Day, Ye -25-1939	South	Carolina
fand wow	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limits
th the Maryiar or 28a-f show a notified at	MD NA	Bal	timore				1 XYes 2 No
with the Mar a or 28a-f si be natilised	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Coul	ntry?
s 23a must b	506 S. Bentalou Stree	12. Was Decedent Ever in U.S.	21223			USA	1.0
036 urs after death v int; or Items 236 marinat must by Funeral	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🛣No	If Yes, specify Cub	Hispanic Origin? (Specify Y pan, Mexican, Puerto Rican	, etc.)	14. Race - Americ Black, White,	
Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Maryland it and Mental Hygene. It is marked other than "netural", or items 23e or 28e-f show traumatic event, the Madical Entitle or mould be notified at To Be Completed by Funeral Director	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2X No	Specify:		Specify: Blac	ck
21215-003 ed within 72 hours regione. ive than 'natural; ive the Medical Exit	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Decedent's Usual Occup (Give kind of work done life DO NOT use retire	pation during most of working d)	16b	. Kind of Business/In	dustry
nd 2121 e filed withir al Hygiene. other than vent, tra Ma	Elementary/Secondary (0-12)	College (1-4or 5+)	Housewife			Domestic	
Ind 2 be filed tal Hygin d other event, II	17. Father's Name (First, Middle, Last)			18. Mother's Name (Firs.	t, Middle, Maid	den Sumame)	
Maryland 2 should be and Mental is marked o raumatic eve	Charles Alston 19a. Informant's Name/Relationship (7			Rosa Mae Moy			
	Arthur Alston/Son	ype, Print)	19b. Mailing Address (Street 3454 Cardenas Av				Code)
ore, M	20a. Method of Disposition	20b. Pla	ce of Disposition (Name of netery, crematory or other pla	Date	MD 2121 20c	Location - City or To	own, State
	1 XBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	nemovalitom state !	Zion Cemetery	11-09-05	La	nsdowne, MD	
Baltimore, permit. Pages 1 at Important: if Item any injury or othe	21. Signature of Funeral Service Licen.	600	22. Name and Addre	,	:1 0.	7.1.	
20244	23a. Part1. Enter the disease, or comp	lications that caused the death.		1 Home 638 N. G		. Balto, MD	2121 / Approximate
Physician	23a. Part1. Enter the disease or comp shock, or heart failure. List only of Immediate Cause (Final	ne cause on each line.)	Interval Between Onset and Death
/Medical	disease or condition resulting in death)	Due to (or as a conseque	grievio Scleve	stic Voses	icr /	1,3800	Un known
Examiner	Sequentially list conditions,	b	non of):				
9, executed on and ial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (01 43 2 001)36446	1100 01).				
58760, icate be executed physicien and s the burial-transit	that initiated events resulting in death) Last	Due to (or as a conseque	nce of):				
68760, ilicate be ex g physicien is as the burial edical E)	•	d					
Box 6 seth certific attending F for use as	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnance				23d. Date of delive	201
Ecrifi ecords, P.O. Box 68760, law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit pleted by Physician/Medical Examir	in the next 10 months?	1 Live birth 2 Fetal d 4 Pregnant at time of dea		у		Month	Day Year
S, P.O. E es that the deargened by the at by delached if by Physici	9 □Unknown	9□ Unknown					
Cords, P cords, P we requires that should be deta		ntributing to death but not result	ing in the underlying cause gr	ven in Part I. 2	3e. Did tobacc	co use contribute to the 2 No 3 Prob	
w requirements should	- Hi	100/63		2	4a. Was an		psy findings available
~ o - c = E					autopsy performed	? prior to co. death?	mpletion of cause of
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State of Maryland / Department of Health and Mental Hygiene 0 0 5 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) [□]30 2005 October **Physician** Carl M. Cole 12:20AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Knollwood Manor Millersville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov 6 1948 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months XXM 2□ F 217-50-9446 56 Yrs. Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f ehow the Medical Examiner must be notified at Yes 2□No Maryland Anne Arundel Annapolis 4 8 1 Directo 10g. Citizen of What Country? 10e. Street and Number 1901 B. Copeland St. 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian e filed within 72 hours after dal Hygiene.
other than "natural", or item Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes X No Specify: Black Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien important: If them 27 is marked other the any injury or other traumatic event, the 12th Laborer Self Employed 6yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Cole Dorothy Myers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jean Hill(Sister) 1901 B Copeland St. Annapolis, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory 11-2-05 Baltimore, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Wm Reese & Sons Mortuary, P.A. 821 West St. Annapolis, Md. 21401 Larry 12. Deese 100 /83 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LOST Physician M /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ed by the ettending physicien and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ SHR 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificete has autopsy 2 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician:
24 hours effer death.
 Funeral Director: Affer this certifice. 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 School 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation **↑** Aatural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide cai 29a. Certifier 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 29b. Signature and title of certife 10/3/2005 D39036 m Dark Drum Chish, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 210 7 31. Date filed (Month, Day, Year) State 8 2005 Registrar

Amend Type or Print in Black Indelible Inkr Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 05 35965 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year 7:03Pm Eloise *lemory* November 6 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Northwest Randallstown
Under 1 Year | If Under 24 Hrs. 8. Hospita 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1 ☐ M 2 💢 F Director Yrs 59 MD 214-56-9855 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai', or items 23a or 28a-f show Examiner must be notified at Director 1 Yes 2 No MD NA Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A.

14. Race - American Indian,
Black, White, etc. 3601 Springdale Ave 21216 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married 10 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", Black Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 2yrs Case Worker State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any lighty or other traumatic event 2008. Be Richard Howard Lyons Mary Florence Trotman 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3601 Springdale Ave. Baltimore, Md 2.

20b. Place of Disposition (Name of Date Date 20c. Location · City or Town, State Crownsyille Vet. 11-14-2005 Crownsyille, MD Maryland National 11/10/05 John A. Demory-Husband 21216 20a. Method of Disposition 1 ☑ Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, MD 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21. Signature of Funeral Service Licensee 21215 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart allure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic cancer luna non Small /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner end I-transit The law requires that the death certificate be executed Due to (or as a consequence of) attending physician for use as the burial Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes faile renal 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Wasan autopsy performed? Yes 2 No Anemier of chronic inflammation certificate 1 Yes Division of Vital Was case referred to medical examiner? Be 26. Place of Death / Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 2 ER/Outpatient 3 DOA HIS After this 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: Injury at Work? To the Hospital or Attending 5 Pending investigation death. within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 11 Certifying Physician: To the best of my knowledge death occurred at the time, detect, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D28462 6,2005 Socion November 30. Name and address o who completed cause of death (Item 23a) (Type, Print) Northwest Hospital Center Randallstown, Maryland Boston

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 0 8 2005

ORIGINAL

Bloom It Specker

32. Registrar's Signature

Description Description				1 - For State Registrar	e of Maryland / De	partment of He ertificate of D	ealth and M Death	lental Hygie	2005	35966
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		10			cause of death (Item 23a) (Typ	e. Print)				
B. PAREKH MD. 1908 HARFORD ROAD, FALLSTON MD 21024		4				FORD ROF	HD, FA	LISTon	/ MD 2	.1024
State Registrar NOV 0.8 2005 32. Begistrar's Signature					32. Registrar's Signature	hacks)				

State of Maryland / Department of Health and Mental Hygieze 0 0 5 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 2:03 PM John. Diggs 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GOOD SAYAKITAN HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1₹M 2□F Director 217-24-4761 76 March 13,1929 Maryland Usual Residence of Decedent the Marylan 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be retilied at 1 ☐ Yes 2 No Directo Maryland Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18 Beehive Place, apt. K death Funerai 21030 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces: 1 Myes 2 □ No If Yes, Give Year or Dates: 1951-53 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other then any injury or other freumatic event, the Mang Mang. 12 n/a Printer Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Clay Diggs, Sr. Beulah Mae 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Virginia C. Diggs/Wife 18 Beehive Place, apt. K. Cockeysville, MD 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Oaklawn Cemetery Nov 5, 2005 Baltimore, Maryland 21. Snat Disum r Service Licenton Dryan W. Clary 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 23a. Part1. En or the Isease, or complications that caysed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on pech line. Approximate Interval Between Onset and Death Immediate Ca. se Final disease or con-SEPSIS Physician resulting in death) /Medical Due to (or as a consequence of): **Examiner** PNEUMONI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Cineaus of Figury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, by Physician/Medical as attending for use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Ö he 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, CORONARY ARTERY DISCASE 1 Yes 2 No 3 Probably 4 Unknown Completed NELLITUS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate PEKISHER AC VASCULAK 2 X No 2 X No Division of Vital 1 Yes 1 TYes Hospitei or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 XNo 2 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 24 hours at 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2 ABOUGERGI, MD RES 000 11,02,2005 30. Name and address of see son who completed cause of death (Item 23a) (Type, Print) GOOD SAMARITAN HOSPITAL, BACTIMORE MARWAN ABOUGERGE 32. Jegistrar's Signature State Registrar

			For State Registrar	State of N	Marylan		artment <i>rtificate</i>			nd Me		iene	005	35968
1	Physici	2.0	1. Decedent's Name (First, Middle, Last)							2	Date of Death Month Day Year			3. Time of Death
	/Medic Examin		Mildred Ziethen Daneker								November 6,		, 2005	3:10 A M
)		er	4a. Facility Name (If not institution, give street and number) Roland Park Place				4b. City, Town, or Location of Death Baltimore City			у	4c. C		County of Death	
	Funeral Director		212-09-3665	- N. W.	Age (In yrs. 89	last birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min.	Date of Birth (Month, Day, 9/19/19	916	Co	hplace (State or Foreign untry) :yland
	and	tor	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Maryl f aho		MD Baltimore Hydes ¹□Yes 2⊠No											
	alter death with the Maryland or Items 23s or 28s-f show miner must be notified at	Director	10e. Street and Number	1101.6	iiyu		10f. Zip Code					0g. Citi:	zen of What Co	untry?
			5020 Elder Road	5020 Elder Road				21082					USA	
	ems erns	Funerai	11. Marital Status	12. Was Deceder	nt Ever in U. s?		 Was Decedent of Hispanic Origin? (Spe- If Yes, specify Cuban, Mexican, Puerto F 						14. Race - American Indian, Black, White, etc.	
9	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Infinite and 18 of 18 and	by Fu	1 Never Married 2 Married 3 ☑ Widowed 4 Divorced	1 ☐ Yes 2			_	☐ Yes 2X No Specify:					Specify: White	
15-0036			15. Decedent's Education 16a				a. Decedent's Usual Occupation					16b Kir	nd of Business/	Industry
<u> </u>	within 72 hours ene. then "natural", he Medical Exp	Completed	College (1-4075+) Tea				e kind of work done during most of working DO NOT use retired)				'			
7	filed wit Hygiene Sther the	Com					acher				Educat			n
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	hould d Mer narks natic		Frederick A. 2 19a. Informant's Name/Relationship			10h Mailia	- Add /	(Ct-0-1	Mab		Nagel	0.5	Town, State, 2	
<u> </u>	th and 2 st		Mark Daneker/sor								Maryl	•	21 082	up Code)
ē,	s 1 er f Hea itam other		20a. Method of Disposition		1 ^	face of Dispo	sition (Name	g of		Dat			cation - City or	Town, State
Ē	Page nent o int: ff iry or		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci			ltimore			, l	11/09	/2005	Bal	timore,	Maryland
baitimore,	permit. Departmitimporta Importa any inju		21. Signature of Funeral Service Gensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland 21204											
			23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate											
>	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) AULTIPLE MYELOMA 3 VIS											
	/Medical Examiner	niner		Due to (or a	as a consequ	uence of):								
-			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		as a consequ	uence ot):								
ĵ	icate be executed physicien and the burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or a	Due to (or as a consequence of):									
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٥	ding p	Med	IF FEMALE:	22a If you average										
.c. go	w requires that the death certifi been signed by the attending should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1						<u>'</u>			23d. Date of delivery Month Day Year		
ν, Τ	s that gned b	by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death?			
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ı Kecords,	The far ate has page 2	Completed					-				24a. Was ar autops perform 1 Yes 2	У	prior to d	topsy findings available completion of cause of
or vital	Attending Physician: r death. ector: After this certific by the funeral director.	Be	25. Was case referred to medical examiner?	Unamital.						of Death (Check only on			
	Physi this c	. To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other. Wursing Home 5 Residence 6 Other (Specify)										ufy)	
5	ding h. After funer	tion	1 Natural 5 Pending 2 Accident investigation		28c. Injury at Work? M 1 ☐ Yes 2 ☐ No			8d. Describe how injury occurred						
UNISION	To the Hospital or Attending Physician: into 24 hours alter death To the Funeral Director: After this certific completely filled in by the funeral director,	ertification:	3 Suicide 6 Could not b				8f. Location (Street and Number or Rural Route Number,							
5		Cert	building, etc. (Specify) City or Town, State)											
		Medical	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
)	To t withi To tl	W	29b. Signature and title of certifier Fleleuw. GleharTII MD 29c. License number 333400							25	29d. Date signed (Month, Day, Year)			
	8		Jelleuw Gehavalle MD 33400 11/07/2005 30. Name and address of personano completed cause of death (Item 23a) (Type, Print) TREVEN W IGENMOTITE MD 6301 NCHAMES ST BALTIMONE, MD 25212											
j	Sta	te	31. Date filed (Month, Day, Year)	32. Regis	strar's Signa	turb of b	,							
	Registr	ar	HOV 0 8 2005	Man sec	35° F									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Carlos Juanito Duldula_o October 31, 8:00P M 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 834 Quince Orchard Blvd. Apt T-1 Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 6. Sex 1₽M 2□F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Director 562-78-1778 1942 Philippines Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits s 23a or 28e-f show 1 X Yes 2 □ No Completed by Funeral Director Maryland Montgomery Gaithersburg 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 834 Quince Orchard Blvd. Apt. T-1 20878 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. The Mudical Examiner: 1 NYes 2 □ No If Yes, Give Vietnam Year or Dates: 1 Never Married 2 Married ŏ 1 ☐ Yes 2 X No Specify: Filipino 3 ☐ Widowed 4 ☐ Divorced "netural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Chef Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H tent: If item 27 is marked out Be S. Gregdrio Duldulao Lucila Domingo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20878 Alicea R. Duldulao/Wife 834 Quince Orchard Blvd., Apt. T-1. Gaithersburg, ML other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 ☐ Remova from State Montgomery Crematorium, 11/04/2005 ō permit. Page Department of importent: If any injury or once. Bethesda, Maryland ` 4 ☐ Donation 5 OyKar (Specify) 21. Signatury of Funer; Robert A. Pumphrey Funeral Home/Rockville, Inc. M00877 300 West Montgomery Avenue, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Atherosclerotic Cardiovascular Disease resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-translt that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signe should be d Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed' 2 No 1 🗌 Yes 2 X No or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 A Residence 6 Other (Specify) Certification: To 1 X Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending within 24 hours after death. To the Funerel Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D51916 November 4, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patricia Tomsko Nay M.D. 11119 Rockville Pike, G-100, Rockville, Maryland 20852 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

			1 - For State Registrar	State of Ma	ryland /	Depa Cer	rtment tificate	of H	ealth a Death	and M	ental Hyg	iene	15	3597	70
	Physici	an	1. Decedent's Name (First, Middle, Last)								2. Date of Deat Month	h Day	Year	3. Time of 0	
	/Medic Examir	cal	Charlott 4a. Fecility Name (If not institution, give stra	eet and number)	Dug	gger	4b. City, 7		Location o	of Death	October	18,2005 4c. Count		2:15pm	1 М
	Funeral Director		232-00-0423		(In yrs. last	birthday) Yrs.	If Under Months	1 Year Days	More If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, Oct. 7,	Year) 1951	Cou	place (State or intry)	
	death with the Maryland ms 23a or 28a-f show firsted by notified at	tor	Usual Residence of Decedent 10a. State 10b. County MD		10c. City, To		more							10d. Inside City	
	with the	Director	10e. Street and Number 3720 Pennington	Ave			10f. Zip	Code 21226	5		1	0g. Citizen of USA	What Cou	intry?	
020	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or Items 23e or 28e-f show aumstic event, the Medical Examinet must be notified at	by Funeral		Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give Year or Oates:		'	Vas Decede	ent of His	spanic Orio	gin? (Spe i, Puerto l	cify Yes or No- Rican, etc.)	14. Ra	ck, White,	can Indian, , etc. ite	
0-01717	ad within 72 ho giene. er than "natur. ; tre Medical i	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	tion completed) College (1-4or 5-		(Give life. L	lent's Usual kind of work DO NOT use omemak	k done d e retired)	uring most	t of working	ng	Own I		ndustry	
Jama	uld be fite Mental Hy arked oth	To Be (17. Father's Name (First, Middle, Last) Charles Leeson								(First, Middle, M y Hanna	Maiden Sumai	ne)		
, Mar	and 2 sho ealth and I n 27 Is me		19a. Informant's Name/Relationship (Type Tina Leeson / Daug		1						Route Number			o Code)	
panimore	permit. Pages 1 and 2 should i Department of Health and Men Important: If Item 27 Is marke any injury or other traumatic o		20a. Method of Disposition 1 ☐ Burial 2 [2 Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	ceme	tery, cren	sition (Nam natory or oth Crema	her place		Oct. 20	24.	20c. Location Baltin	-		
סמור	permit. Departr Import any inj		21. Signature of Funeral Service Licensee			22	Charle 1501	es L.	Steve	y ens Fu	neral Hom	ne Inc. MD 21230)		
,00/00,	Centificate be executed Medical Physician and India physician and India transit Physician and India transit Physician and India transit Physician and India transit Physician and India transit Physician and India transit	dical Examiner	23a. Part1. Enter the disease, of complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Due to (or as a	consequence	ce of):	EM/				respiratory arre	sst,		Approximate Interval Betwo	een
O. BOX O	ath certif attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 □ No 9 □ Unknown	. If yes, outcome of 1□Live birth 2 4□Pregnant at t	Fetal dea		Ectopic pre						ite of deliver		a r
orus, r	w requires that the deben signed by the should be detached	þ	Part II. Other significant conditions contri	buting to death bu	t not resulting	g in the ur	nderlying ca	use give	n in Part I.		23e. Did tob		tribute to t	he cause of de	
U U	The lay ate has page 2	Completed									24a. Was ar autops perform	ned?	Were auto prior to co death? 1 Yes	opsy findings as impletion of car	vailable use of
<u> </u>	Physician: The ribis certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes	spital: 1 ☐ Inpatien	t 2□EB/	Outpatien	3 DO	Othe	_		(Check only on		os (Sasai	6.1	
	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	ation: T		28a. Date of Injury (Month, Day		Time of Injury		c. Injury Work		2	8d. Describe ho			y /	
DIVISION	ital or Atters after de al Directo	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc.							8f. Location (St City or Town	, State)			er,
	the Hospi in 24 hou the Funer ipletely fill	ledical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	ian: To the best of r: On the basis of and manner stat	examination	lge, death and/or inv	occurred a estigation,	it the time in my op	e, date and inion, deat	d place, a th occurre	nd due to the ca ed at the time, da	use(s) and mate and place,	anner as s and due to	tated. o the cause(s)	
	or with	Σ	29b. Signature and title of certifier	- gro	200	2	H	License	54°	970) 29	10/2	1		
	Sta	ate	30. Name and address of person who com 20 E. Timor 31. Date filed (Month, Day, Year)	JIUm	RI	<	UITE	-	42C	9	Time	NIUV	nn	10 210	93
	Regist		NOV 0 8 2005	32 Registra	1	GO									

			1 - State Registrar	ate of Maryland / Dep Ce	partment of He ertificate of De	ealth and M eath	lental Hyg	giene 0 0 5	35971
	Physici	an	Decedent's Name (First, Middle, Last) Tillie Davi	.doff			2. Date of Dea Month	Day Y	3. Time of Death
W	/Medic		4a. Facility Name (If not institution, give street		4b. City, Town, or Lo	ocation of Death	Oct	4c. County of	005 2 · 20 PM
	- Admin		Sinai Hospital	of Baltimere	Baltim		•		
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M	7. Age (In yrs. last birthda) 2 7 90 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Sept. 13	Year) 9 ,1915 1	. Birthplace (State or Foreign Country) Providence, RI
	ow ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
	e-fsh	ctor	WD N/3	Balt	imore				1.5 1es 2 □ No
	th with the	al Director	10e. Street and Number 25 West Belveder	e Avenue	10f. Zip Code	21215		10g. Citizen of Wha	at Country?
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatin and Mentalle Hygiene. Department of Heatin and Mentalle Hygiene. The Maryland of Heating and Mentalle of the than "natural", or Items 23a or 28a-f show any injury or other treumatic event, Ite Madical Examinating mentalle motified at an once.	by Funeral	1 Never Married 2 Married 1	/as Decedent Ever in U.S. mmed Forces? Yes 2	. Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 ☑ No	panic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. White
5-0	72 ho	eted	15. Decedent's Education (Specify only highest grade con	npleted) (Giv	edent's Usual Occupations and of work done dur		ng	16b. Kind of Busin	ness/Industry
121	within ene. than	Completed		Ollege (1-4or 5+)	DO NOT use retired) Homemaker	•		Own Ho	me
ر ام	it Hygin	Be Co	17. Father's Name (First, Middle, Last)	0	11	8. Mother's Name	(First, Middle,	Maiden Sumame)	
ylar	ould bound Menta	ToE	James Weisman				ne Witc		
Mar	d2sh thand thand 17lsm treum		19a. Informant's Name/Relationship (Type, F Martin Davidoff / S		lling Address (Street and Pepperdine				
ē,	s 1 an f Heal Item 2		20a. Method of Disposition	20b. Place of Dis		1 0	-	20c. Location - Cit	
<u>E</u>	Page ment o ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removed 4 ☐ Donation 5 ☐ Other (Specify)	val from State Ceclar Pa		10-24	+- 05	Para	mus, NJ
Baltimore,	permit. Departi		21. Signature of Funeral Service Licensee		22. Name and Address Charles L. 1501 Fast F	of Facility Stevens Fl	meral Hor	me Inc.	
	hysician be executed // Medical Examiner superprise sup	Examiner		Due to (or as a consequence of): Due to (or as a consequence of):	nter the mode of dying,	such as cardiac o	or respiratory arr	rest,	Approximate Interval Between Onset and Death
Box 6	t the death certi by the attending ached for use a	by Physician/Medical	in the past 12 months?	☐ Pregnant at time of death 5☐ Unknown	□Ectopic pregnancy □ Other (specify)	in Part I	22a Did to	23d. Date of Month	-
rds,	quires than signed and and and and and and and and and an	d by	Insula deper	4 1			1 🗆 Y		Probably 4 Unknown
		Completed	-				24a. Was a autops perform	sy prio med? dea	re autopsy findings available r to completion of cause of th? Yes 2XNo
Zita Zita	sicien certifi rector	Be	25. Was case referred to medical examiner?	al:	Othor	26. Place of Death			
0 ر	D - 42	n: To	1 Yes 2 No	al: 1 Inpatient 2 ☐ ER/Outpati a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at	4 Nursing Ho		ence 6 Other (ow injury occurred	(Specify)
sior	eath. eath. or: Af	catio	2 Accident investigation	(Wohl), Day 1627 Hijury		s 2 No			
DIX	s after d s after d al Direct ad in by	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28	 e. Place of Injury - At home, farm, s building, etc. (Specify) 	street, factory, office		28f. Location (Si City or Town		or Rural Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medicai ((Check only 2 Medical Examiner: (n: To the best of my knowledge, dea On the basis of examination and/or and manner stated.	ath occurred at the time, investigation, in my opin	date and place, a	and due to the c ed at the time, d	ause(s) and manne late and place, and	er as stated. I due to the cause(s)
	To the within To the comp	W	29b. Signature and title of certifier	0	29c. License n			9d. Date signed (A	**
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	10		30. Name and address of person who complete Nastaran Rafi			of Balt	imare		
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as Tillie Davideft

Patient Knewn

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	Discourse		1. Decedent's Name (First, I	liddle, Last)									2. Date of De				e of Death
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	Funeral Director		5. Social Security Number 457–80–9 886 7886		M 2□F		(In yrs. Ia 54	st birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da 06/21	th y, Year /19	9. E 51	Birthplace (Sta Country) TX	te or Foreign
	land		Usual Residence of Deceder 10a. State 10b. Co				10c. City,	Town or Lo	cation							10d. Inside	City Limits
	Many -f sh	ţo	MD	Bba	ltimor	re					Balt	imor	е			13/232	es 2 □ No
	r 28a	Director	10e. Street and Number						10f. Zi	p Code				10g. C	itizen of What	Country?	
	h witi		47 Odeon C	ourt							212	234				USA	
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show amy injury or other traumatic event, the Mudical Examinational Landing and page.	Funerai	11. Marital Status 1 ☐ Never Married 2 X	-	2. Was Dec Armed Fo	orces? 2 ⊠% ≪		1	f Yes, spe	cify Cuba	n, Mexica	n, Puerto	ecify Yes or No Rican, etc.)) -	Black, W		
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<u>6</u>	Heal Heal tem 2		20a. Method of Disposition				20b. Pla	ce of Dispo	sition (Na	me of			Date		ocation - City		
ē	Pages ent of nt: if i		1 ☐ Burial 2 ☐ Crema 1 ☐ Donation 5 ☐ Oth		emoval from	State	Seas	metery, cren side M	em.	other plac Pk. C	em.	11/0	1/2005	Corp	ous Chr	isti.	TX
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			23a. Part1. Enter the diseas	e, or compli	cations that	caused t	he death.	Do not ente					renue,		imore	Approxir	nate
	Physician		shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	List only on	Seps).									Onset at Week	nd Death
	/Medical Examiner		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				conseque		17 - 4 1	1							
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. Box	The law requires that the death certific site has been signed by the attending p page 2 should be detached for use as	Physician/M	23b. Was decedent pregnar in the past 12 months?	t 23	4☐Pregr	birth 2 nant at ti	f pregnand Fetal of me of dea	death 3□	Ectopic p						23d. Date of o Month	lelivery Day	Year
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s,	res tha igned be dei	by	Part II. Other significant con	iditions con	tributing to d	leath but	not result	ting in the ur	nderlying	cause give	n in Part	1.			use contribute		1
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									5				1 Yes	rmed?	death		
Vital		Be o	25. Was case referred to me examiner?		ospital:					Cthe	ar.		(Check only o				
o	Phys r this ral di	1: To	X Yes 2 No 27. Manner of Death		28a. Date	Inpatient of Injury	2	R/Outpatien 28b. Time of		JA	4 🗆 N		me 5 Residence 128d. Describe 1			pecify)	
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	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edicai (29a. Certifier X Cer (Check only one) X Med	ifying Physical Examin	ician: To the er: On the b and man	asis of e	examination	ledge, death on and/or inv	occurred estigation	at the tim	e, date a pinion, de	nd place, ath occurr	and due to the ed at the time,	cause(s) and manner	as stated.	
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) () an	MIL	ME	>			PI	9812	۷.		90	ct.	31, 2	:005	
	V		30. Name and address of pe	rson who co	mpleted caus	se of dea	ath (ftem 2	23a) (Type, i	Print)								
	۲]	Paola G. Pie		MD 22	S.	Gre	ene	Stre	et,	Bal	timo	re, Mo	1 2	1201		
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			For Stata Ragistrar	State of Ma	ryland / Depa	artment of He		ental Hygiei	711115	35973
	Physici /Medic		1. Decedent's Name (First, Middle, MLL & A	ELLIS				2. Date of Death	Day Year	3. Time of Death 55/5 P M
-	Examir Funeral	er		RITAN HO	SPITAZ (layrs. last birthday)	4b. City, Town, or BACT / If Under 1 Year Months Days	more	8. Date of Birth (Month, Day, Ye.	BACTIM 9. Birthp ar) Gour	ORE CITY lace (State or Foreign
	Director Moye Moye	or	Usual Residence of Decedent 10a. State 10b. County		Yrs.			60: 4,19		The Carolina Od. Inside City Limits 1 X Yes 2 □ No
	death with the Maryland ms 23a or 28a-f ehow rnwat be notified at	Funerai Director	10e. Street and Number 4739 Ad	Lhambr	a Ave	10f. Zip Code	218	10g.	Citizen of What Cour	
9036	72 hours after des neturel', or Items Jisel Examiner m	by	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ◯ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cuban	spanic Origin? (Spe n, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: B	an Indian, etc. ACK
21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If item 27 ie markad other than "neturel", or Items 23a or 28a-f ehow or other treumatic event, the Medical Eradiner mark be notified at	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	S Education grade completed) College (1-4or 5+	(Give	dent's Usual Occupal kind of work done du DO NOT use retired	tion uring most of working	16b	Cathor Crch die	dustry CC SE
Maryland	should be fill and Mental Hy e markad oth umatic event	To Be	17. Father's Name (First, Middle, L. 19a. Informant's Name/Rejationshi	Loc	Khart 19b. Mailin	-	18. Mother's Name Output Date Output Date Output Date	ay	len Sumame) Brodd y or Town, State, Zip	(Code)
Baltimore, M	t. Partmer		20a. Method of Disposition 1 Squrial 2 Cremation 4 Donation 5 Other (Spo	ecity)	20b. Place of Disponentery, cree	position (Name of matory or other place) Nem mal 2. Name and Address	PC 11/11	105 R	Location - City or To	arn, md.
	Para in the permit of the per		23a. Pard. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition	nly one cause on each line	the death. Do not ent	any fino	arch tu	neral to	me. Bad	O. M. Z. 1227 Approximate Interval Between Onset and Death
8760,	/Medical Examiner bhysician and the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a Due to (or as a c. Dec Due to (or as a	consequence of): NARY 7 consequence of): UB17(US) consequence of): NAL F	RACT ULCO AILURG	INFECT PR	ION		
.O. Box 68	death certifi e attending i id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome o 1 □Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ory Day Year
s, P	w requires that the been signed by th should be detache	by	Part II. Other significant condition	rescontributing to death but	t not resulting in the u	nderlying cause giver	n in Part I.		co use contribute to the	ne cause of death?
of Vital Record	The law ate has b page 2 sl	e Completed	DEMEAN PNEUN 25. Was case referred to medical				26. Place of Death	24a. Was an autopsy performed 1 Yes 2 (Check only one)	prior to cor death?	psy findings available inpletion of cause of
Division of V	t or Attending Physicien: after death. Director: After this certific I in by the tuneral director,	Certification: To B	examiner? 1	28a. Date of Injury (Month, Day	t 2 ER/Outpatier Year) 28b. Time o Injury y - At home, farm, str (Specify)	ont 3 DOA Other f 28c. Injury Work? M 1 Y	at 2 Nursing Homes	ne 5 Residence 8d. Describe how in	and Number or Rura	
L	Hospite 4 hours Funeral	ledical Ce	29a. Certifier 1 Cartifying (Check only one) 2 Madical E	Physician: To the best of xaminer: On the basis of eand manner state	examination and/or in	h occurred at the time vestigation, in my opi	e, date and place, a inion, death occurre	nd due to the cause d at the time, date a	o(s) and manner as st and place, and due to	ated. the cause(s)
	To the To the Complet	Me	29b. Signature and title of certifier 30. Name and address of person w	MD ho completed cause of dea	ath (Item 23a) (Type,	29c. License DOO Print)			Date signed (Month.	
歐	Sta Registi		DR MAW N 31. Date filed (Month, Day, Year)	32. Begistrar	ath (Item 23a) (Type,	ARITAN	thus 17	iaz, G	BALTIMON	43
	3		NOV 0.8	2005 Magaza	2 N. 18					

Amend Please Type or Brint in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

SYKESVILLE 10g. Sixeed and Number 10g. Citizen of What Country 10g. Citizen 1			Certificate of Death	,	Reg. 2.005	35974
Scale Sample Sa	Physicia	2	Decedent's Name (First, Middle, Last)			3. Time of Death
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The property of the property	/land		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
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15. Decedent's Education 16. Kind of Bosiness/Inclusive 16.		5	Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, V	
15. Decedent's Education 16. Kind of Bosiness/Inclusive 16.	8 5 E	2	If Yes, Give 1 □ Yes 200 No Specify:		Specify:	WHITE
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Sequentially list conditions, a large larg	Examiner		resulting in death)		<u></u> -	1
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Amend item#20b, perFh, C849, 11-8-05 TT State of Maryland / Department of Health and Mental Hygiers 0 5 35975 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death **Physician** 3) 1.0 10:1 2005 /Medical Examiner 4b. City, Town, or Location of Death 4c. County of HOSPITAL Birthplace (State or Foreign Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours 2 🗆 F Min Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10b Count 10d. Inside City Limits must be notified at To Be Completed by Funeral Director 1 es 2 No 10g. Citizen of What Country? itams 23a Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. other traumatic event, the Mudical Examiner Never Married 2 Married 5 Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Kysiness/Industry al Hygiene. Condary (0-12) College (1-4or 5+) s Name Middle, Mi ie marked of Health a Method of Disposition Department of important: If it any injury or o one. ō → Qurial 2 ☐ Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death EPSIS Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by ZCILA 3 Probably 2 🗆 No FIBRULATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 🗆 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 2 No 1 Yes Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending To the Hospital or Attendi within 24 hours affer death. To the Funeral Director; A 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) DO061765 OCTUBER 31 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CISENE ZEV CONTROP SOUTH CHANCES ST GOI MATI MINE 32. gistrar's Signature 31. Date filed (Month, Day, Year) NOV 0 8 2005 Registrar

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OCME October, 30, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LING LT, MR TILL Penn Street Baltimore, Maryland 21201 State 31. Date liled (Month, Day, Year) 22. Registrar's Signature	Ö	after i Dire	erti	4 Homicide determined build	ding, etc. (Specify)			City or Town,	State)	
OCME October, 30, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LING LT, MR TILL Penn Street Baltimore, Maryland 21201 State 31. Date liled (Month, Day, Year) 22. Registrar's Signature		Hospite 24 hours Funara stely fille		(Check only 2 Medical Examiner: On the	basis of ex	amination and/or inv	n occurred at the	ne time, date and place, and my opinion, death occurred	d due to the caus at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
OCME October, 30, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LING LT, MR TILL Penn Street Baltimore, Maryland 21201 State 31. Date liled (Month, Day, Year) 22. Registrar's Signature	_	ro the vithin of the comple	Me				29c. Lic	cense number	29d	. Date signed (Month	h, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LING LT, MIR 111 Penn Street Baltimore, Maryland 21201 State 31. Date liled (Month, Day, Year) 2. Registrar's Signature		F > F 0		I his his, mid	•		0	CME	Oct	ober, 30,	2005
State 31. Date liled (Month, Day, Year) 2. Registrar's Signature				30. Name and address of person who completed cau	use of deat	h (Item 23a) (Type,	Print)			-	
State Registrar NOV 0 8 2005 Registrar				4		0:		Penn Street	Baltimo	ore, Maryl	and 21201
				NOV 0.8 2005	Hegistrar's	Signature Los	te				

State of Maryland / Department of Health and Mental Hygietaen O E 25077

Unknov 05-073	
crn	Physician

	991		1 - For State Registrar		Cer	rtificate of i	Death	Reg.		33911
	Physici /Medi		Decedent's Name (First, Middle, La Jermaine Fleming	ist)				2. Date of Death Month November	Day Year 02 200	3. Time of Death 3:30 P M
	Examir		4a. Facility Name (If not institution, gire			4b. City, Town, or	Location of Death		4c. County of Dea	
	and the same	£.3	900 Block Allenda			Balti			N/A	<u> </u>
100	Funeral Director		213-04-0229	5ex 1 M 2 ☐ F	ge (In yrs. last birthday) 23 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 02–20–1982	9. Bir Mar	thplace (State or Foreign ountry) yland
	aryland show	_	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	th the Mi	Director	MD NA 10e. Street and Number			Baltimore 10f. Zip Code		10g.	Citizen of What Co	1 X Yes 2 □ No ountry?
	23a		601 S. Beechfield A	venue			21229		USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Itame 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:	No I	Was Decedent of H fYes, specify Cuba 1 □ Yes 2 🛣 No	ispanic Origin? (Spe in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Blace	e, etc.
9	2 hou ature		15. Decedent's E	ducation	16a. Deced	dent's Usual Occupa	ation	168	o. Kind of Business	
21215	l within 7. lene. r than "n	Completed	(Specify only highest gr Elementary/Secondary (0-12) 12	ade completed) College (1-4or	(Give	kind of work done of DO NOT use retired aborer	during most of worki)	ing	Wareho	•
and 2	id be filed ental Hyg ked other ic event,	To Be C	17. Father's Name (First, Middle, Last Chester Fleming)			18. Mother's Name	Floring		
J.	should Mind Mind Mind Mind	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street a		: TellITig al Route Number, Ci	ity or Town, State,	Zip Code)
ž	and 2 eith a 127 is	i i	Chester T. Fleming/ F	ather	1			alto, MD 212		,,
Baltimore, Maryland 21215-0036	Pages 1 enemon of He		20a. Method of Disposition 1		20b. Place of Dispo cemetery, cren King Memori	natory or other plac	_{ө)} 11–08–0		Location - City or odlawn, MD	Town, State
Balt	permit. Departr Imports eny inju		21. Signature of Funeral Service Lice	nsee .		Name and Addres		638 N. Gilm	or St Rali	co, MD 21217
8	Physician /Medical		23a Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Gu	the death. Do not ente	er the mode of dying	g, such as cardiac o			Approximate Interval Between Onset and Death
	Examiner	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence of).					
60,	rtificate be executed ng physicien and s as the burial-transit	i Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
68760,	physics the l	Medical		d.						
.O. Box (eg p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
S, D	The law requires thet the death sie hes been signed by the etter bage 2 should be detached for u	þ	Part II. Other significant conditions	contributing to death b	ut not resulting in the un	derlying cause give	on in Part I.		Y	the cause of death?
Vital Record	: The law nicete hes be	e Completed						24a. Was an autopsy performed	? prior to death?	topsy findings available completion of cause of
<u> </u>	F in the state of		25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of Death			
ō			1 X Yes 2 No 27. Manner of Death	1 Inpatie		3LI DOA	4 Nursing Hor	ne 5 Residence 28d. Describe how in		cify) at scene
sion	Attending r death. ector: After by the funer	atlor	1 Natural 5 Pending investigation	Found, Da	y Year) Injury	28c. Injury Work	? (es 2∑No	subjec		
Division of	itel or Attenirs after deathrai Director:	Certification:	3 Suicide 6 Could not be determined	e 28e. Place of Inj building, et	ury · At home, farm, stre c. (Specify)	eet, factory, office	2		and Number or Ru late) 900 B(0 May 2 M	ck Allendalest
	o the Hospitel or Attending ithin 24 hours after death. o the Funeral Director: After ompletely filled in by the funer	Medical	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exar	niner: On the best and manner sta	of my knowledge, death f examination and/or inv ated.	occurred at the timestigation, in my op	sinion, death occurre	and due to the cause	a(s) and manner as	stated

To the Hospitel or Attendi within 24 hours after death.
To the Funeral Director: A completely filled in by the fu

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number 29d. Date signed (Month, Day, Year)

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

November 03, 2005

State Registrar

31. Date filed (Month, Day, Year)

COTROL

NOV 0 8 2005



State of Maryland / Department of Health and Mental Hygiene 35978 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year JAMES EDWARD GROSS JR. 2005 November 4 12:00 a^M /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner CHAPEL HILL NURSING HOME BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Director 75 213-28-4968 AUGUST 15 1930 MARYLAND Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County or Itema 23a or 28a-f ehow 10c. City. Town or Location 10d. Inside City Limits traumatic event, the Medical Examinar must be notified at Director 1 Tyes 2/ XNo MARYLAND BALTIMORE RANDALLSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8948 HARKATE WAY 21133 Funerai U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give 51/53 Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Š Specify: BLACK 3 ☐ Widowed 4 ☒ Divorced "naturel". Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. BALTO CITY DEPT OF Elementary/Secondary (0-12) College (1-4or 5+) 12th grade CLEANER SANITATION 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fife Department of Health and Mental Hy Important: if item 27 is marked oth eny lighty or other traumatic event once. Be (18. Mother's Name (First, Middle, Maiden Surname) JAMES E GROSS SR. ADDIE GROSS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8948 Harkate Way, RAndallstown, Md., 21133 Jeffery Gross/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Daurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) GARRISON FOREST 11-09-05 OWINGS MILLS, MARYLAND 21. Signature Funeral Seprice Licensee 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1CARS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably Be Completed 1 Tyes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 20 25. Was case referred to medical 26 Place of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tyes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient this 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 2 Accident investigation 1 TYes 2 TNo Director: the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funeral Direct 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 51051 XI 30. Name and address of person who mpleted cause of death (Item 23a) (Type, Print) ROAD, Ellicott City, MD dres 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

			1 - State Unpend It	State of Market 23a,27,28a	aryland / Dep a-f per me	artment of H C350 12-1 rtilicate of L	ealth an 3-05 <i>beath</i>	d Mental H as	ygiene (35979
,	Physic	an	1. Decedent's Name (First, Midd	fle, Last)				2. Date of D	Day Day	3. Time of Death
	/Medi	cal	Erica			dman		Novem		2005 17:50 ^M
	Examir	ner	4a. Facility Name (If not instituted Union Memorial			4b. City, Town, or Balt	Location of D	eath		ty of Death NA
505	Funeral Director		5. Social Security Number 219–90–0301	10M 20E	ge (In yrs. last birthday) 34 Yrs.	If Under 1 Year Months Days	If Under 24 I Hours N	Ain. (Month, L	irth Day, Year) -71	9. Birthplace (State or Foreign Country) Md.
	and		Usual Residence of Decedent 10a. State 10b. Count	y	10c. City, Town or Lo	ocation		1		10d. Inside City Limits
	the Marylan r 28a-f show notified at	ţo	Md.	NA		altimore				1∑Yes 2 No
	r 28a-f	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	f What Country?
	th with		4003 Chesmon	nt Avenue		21206	5		US	SA.
	items	Funerai	11. Marital Status	12. Was Decedent Armed Forces?		Was Decedent of His	spanic Origin'	(Specify Yes or Nuerto Rican, etc.)	lo- 14. Ra	ace - American Indian, ack, White, etc.
36	a 9 3	by Fu	Never Married 2☐ Ma 3☐ Widowed 4☐ Divorce	If You Give M	No	1 ☐ Yes 2 ☐ No	Specify:	,,	Speci	
Maryland 21215-0036	72 hours natural',		15. Decede	int's Education	16a. Dece	dent's Usual Occupa	ition		16b. Kind of E	Business/Industry
215	d within 7 piene. r then "n	Completed	(Specify only high Elementary/Secondary (0-12)	est grade completed) College (1-4or 5	life	kind of work done d DO NOT use retired)	uring most of	working		,
2	77 - 1 1	Con	llth grade			employed			NA	
and	I be fill H ad ott	Be	17. Father's Name (First, Middle	, Last)			18. Mother's	Name (First, Middi	e, Maiden Suma	me)
2	2 should be f and Mental H is marked of raumatic sve	70	Horace 19a. Informant's Name/Relation	iship (Type, Print)	Goodman	ng Address (Street a		aurie	hor City of Tour	Collins
	B = 2 =		Laurie Tuck	Mother						
e,	of Hea		20a. Method of Disposition		20b. Place of Dispo	D3 Chesmor esition (Name of matory or other place	ı	Date Date	20c. Location	Id 21206 - City or Town, State
<u>.</u> E	Page ment ant: If ury o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (mel Cem.	·	-9-05	Dundal	k, Md.
Baltimore,	permit. Pages. Depertment of I Important: If its sny injury or of once.		21. Signature of Funeral Service	e Licensee	.)	Name and Address Aarch F.H.	,	Ba.	ltimore, E. North	Md. 21202
1.45	(±, _		23a. Part1. Enter the disease, of shock, or heart failure. Lis	st only one cause on each iii	the death. Do not en	er the mode of dying	, such as care	diac or respiratory	arrest,	Approximate
<i>j</i> = -	Physician		Immediate Cause (Final disease or condition	Cardiac Perforat	Tamponade ion Of Sup	Due To He erior Ven	operica a Cava	ardium Du	ie To	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):				ALC ROOF	
9.	· · · · · · · · · · · · · · · · · · ·	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):					
	d d ansit	Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events	1						
o,	be executed iclan and burial-transit		resulting in death) Last	Due to (or as	a consequence of):					
8760,	cate be execu physician and the burial-tra	dicai		d						
9		/Mec	IF FEMALE:	220 Hunn outcome						
Вох	eath certif attending for use a	cian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal death 3	Ectopic pregnancy Other (specify)				ate of delivery onth Day Year
P.O.	by the lached	Physician/Me	1 □ Yes 2 □ No 9 ☑ Unknown	9□ Unknown	- Inno or adam 5					
	Attending Physician: The law requires that the death certific death. rdeath. sctor: Atter this certificate hes been signed by the attending by the funeral director, page 2 should be detached for use as	by P	Part II. Other significant condit	ions contributing to death b	ut not resulting in the u	nderlying cause give	n in Part I.	23e. Did	tobacco use con	ntribute to the cause of death?
of Vital Records,	w require been sig should b							_ 1□	Yes 20 No	3 ☐ Probably 4 ☐Unknown
ecc	elawr hesbe je 2 sh	Completed						24a. Wa	s an 24b.	Were autopsy findings available prior to completion of cause of
<u>~</u>	: The l	ပ္ပ						per 1 X Yes	ormed? 2 □ No	death?
Vita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			0.5	_	Death (Check only		
of	ig Phys ter this neral di	<u>1</u>	1 XYes 2 No 27. Manner of Death	1 1 Inpatie			4 🗀 1 4 GI 3 II 1	g Home 5 Res	how injury occur	
ion	nding Ph ath. r: After th e funeral	ation	1 □Natural 5 □ Pendi 2X Accident invest		y Year) Injury	Work' M 1 □ Y	es 2 X No	During	placeme	ent of superior
Division	er degenerate	Certification:	3 ☐ Suicide 6 ☐ Could	not be	ury - At home, farm, str	eet, factory, office			ava filt (Street and Num)	ter ber or Rural Route Number, LON Memorial
ā	ital ours aft			Hospita	11			Hospita	I, Balti	imore, Md
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medicai	29a. Certifier 1 ☐ Certifyi (Check only 2 ☑ Medica one)	ing Physician: To the best of I Examiner: On the basis of and manner sta	r examination and/or in	occurred at the time vestigation, in my opi	e, date and pla inion, death o	ace, and due to the ccurred at the time	cause(s) and m , date and place,	anner as stated. and due to the cause(s)
	To To t	Σ	29b. Signature and title of certific	er er er er er er er er er er er er er e		29c. License			29d. Date signe	ed (Month, Day, Year)
1	2		Yamah Jora	Mary MB		0.C.M	.E.		Novembe:	r 03, 2005
(30. Name and address of person	who completed cause of d	leath (Item 23a) (Type, 111	_{Print)} Penn Stre	et. Ba	ltimore.	Marylan	d 21201
la ex	Sta	te	31. Date filed (Month, Day, Year) 32. Registri	ar's Signature		, ,	,	- /	
	Regist		NOV 0		w. A. A	reck				

State of Maryland / Department of Health and Mental Hygie 2 005 35980 Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 3, 2005 11:03 P[™] Nov. Greenstreet Mabel /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Glen Burnie Anne Arundel Baltimore-Washington Medical Ctr 8. Date of Birth (Month, Day, Year) Feb. 16, 1925 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 M 2 F Months Days Hours Feb. Yrs. Maryland 80 Director 216-18-6785 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r then "natural", or Items 23s or 28s-f show the Medical Exeminat must be notified at 1 Yes 2 THO Director Maryland Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21060 208 Juniper Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: δ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Hospital N/A<u>Maintenance Worker</u> 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Merk1e Gertrude Grogan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 Juniper Drive Glen Burnie, Maryland 21060 William Edward Scanlon (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Glen Haven Memorial PK. 11/05/05 | Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and} Address of Facility
McCully-Polyniak Funeral Home, P.A.
3204 Mountain Road Pasadena, Maryland 21122 21. Signature of Funeral Service Licenses llen 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition)

Immediate Cause (Final disease or condition) Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) nemory hay n Iva Cerebral **Physician** 3 hrs /Medical Due to (or as a consequence of): Examiner Due to (or as a codsequence of) Curum Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown o 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Fibrillation 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 252 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral. 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide o the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 50470 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print)

SRIDIMR - ATTURY; 8109 Ritchu Pasadeur, MD 21122 0 ATTURY SRIDIMAR. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 8 2005 Registrar

		1- State Amend Items	State of Maryla 23a per Dr.	,G849-1	1/08/05di	beath			5 35981
Phys	ician	Decedent's Name (First, Middle, Last)					2. Date of Deat Month	Day `	3. Time of Death Year
/Me	dical		Joseph T. Go	yak			October		
Exar	niner	4a. Facility Name (If not institution, give s			•	r Location of Death		4c. County of	
		5. Social Security Number 6. Sex		s. last birthday)	If Under 1 Year	nevy Chas	e 8. Date of Birth		Montgomery
Funer Direct		110	M 2□F 89		Months Days	Hours Min.	(Month, Day,	Year)	9. Birthplace (State or Foreig Country)
	OI .	Usual Residence of Decedent	09				February 2	25,1910	Pennsylvania
ylanc		10a. State 10b. County	10c. 0	City, Town or Lo	cation				10d. Inside City Limits
Mar Mar	ţ	Maryland Montg	omery		Che	evy Chase			1 ☐ Yes 2X No
th the	Director	10e. Street and Number			10f. Zip Code		1/	0g. Citizen of Wh	nat Country?
death with the Maryland ms 23e or 28a-f show	<u>a</u>	8816 Alt	imont Lane			20815		Unit	ted States
21215-0036 d within 72 hours after death with the Marylan sjeine. In them "naturel;, or Items 23e or 28a-f show I'm Medical Exulo izer meat be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puert	pecify Yes or No- Rican, etc.)		- American Indian, White, etc.
36 s afte	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 🛣 No If Yes, Give		☐ Yes 2X No	Specify:		Specify:	
5-0036 72 hours after naturel; or Ite	d b	3 Widowed 4 □ Divorced	Year or Dates:	100 David		-4:		10: 10: 1-15	White
15 n 72 n 72 m 1 n 1 n 1 n 1 n 1 n 1 n 1 n 1 n 1 n 1	Completed	15. Decedent's Educ (Specify only highest grade		(Give	ent's Usual Occup kind of work done of ON NOT use retired	ation during most of worl f)	king	16b. Kind of Bus	iness/industry
d 2121 filed within Hygiene. other then "	m C	Elementary/Secondary (0-12)	College (1-4or 5+)		- 1	Worker			Steel
filed Hyginal	ပိ	17. Father's Name (First, Middle, Last)		<u> </u>	Steel		ne (First, Middle, M		
aryland S should be file and Mental Hy s marked oth	To Be	т	ohn Govak				Pose	Mehalio	
aryla should nd Men marke	-	19a. Informant's Name/Relationship (Type		19b. Mailin	g Address (Street	and Number or Ru			
and 2 salth a n 27 ls		Kathleen R. Rosenb	ero/ Daughte	r 88	16 Altimo	nt Lane	Chevy Ch	ase. Mai	ryland 20815
ore, Maryland 2 so 1 and 2 should be filed of Health and Mental Hygir frem 271s marked outler rother traumatic event.		20a. Method of Disposition	20b.	Place of Dispos			Date :		City or Town, State
		1 ☐ Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 🛣 Other (Specify)	emoval from State Entombment	-	Cemeter		ober 2005	Doggoog	Donnaulwania
THE STATE OF	ej	21. Signature of Fyneral Service License		22.	Name and Addres	ss of FacilityRob	ert A. P	umphrev	Pennsylvania Funeral Home
Deprin	once		shot MOO.	335 Bei	hesda-Ch hesda. M	levy Chas laryland	e. Inc. 20814-35	7557 Wis 01	sconsin Avenu
	16°	23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on							Approximate Interval Between
Physicia	10 ·	Immediate Cause (Final disease or condition							Onset and Death
/Medic		resulting in death)	Cardiopul Due to (or as a conse		Arrest				Minutes
Examin	er	Coguantially list conditions h	Coronary	Artery	Disease				vears
P ==	ner -	Sequentially list conditions, it may be be cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	grience of					
68760, filicate be executed a physician and as the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last							
50, be ex	<u> </u>	, sooning in coain, and	Due to (or as a conse	equence or):					
687 ficate the physics the the	edical	d	l						
OX 6 h certific anding p		IF FEMALE:	3c. If yes, outcome of preg	nancy				221.5	
m ta ta o	Physiclan/M	in the past 12 months?	1 Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	ital déath 3 🗌	Ectopic pregnancy Other (specify)			23d. Date Monti	
of the de by the attached itached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	death 5	Other (specify)				
IS, P. res that t igned by be detail	Ph	Part II. Other significant conditions con	tributing to death but not re	asulting in the un	derlying cause give	en in Part I.	23e. Did tob	acco use contrib	oute to the cause of death?
ds, uires sign d be	d by						1 🗌 Ye	s 2 🗆 No 3	I □ Probably 4 X Unknow
cord w require been si	ete						24a. Was ar	24b W/s	ara gutangu findinga gunilahli
Re lav	ompleted						autops	v pri	ere autopsy findings available or to completion of cause of ath?
al Bo	O	OF Was asses referred to modical					1 ☐ Yes 2	X No 1□	Yes 2 No
of Vital Physician: This certificatel director, p	Be	25. Was case referred to medical examiner? 1 X Yes 2 No	ospital:	TER/O	3□ DOA Othe		th (Check only one		
Of Phys	1. To	27. Manner of Death		ER/Outpatient	28c. Injun	4 Nursing H	ome 5X Reside 28d. Describe ho		
On On Iding Fig.	후	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Worl	<br Yes 2 □ No		, , ,	
Division of Vital Records, el or Attending Physician: The law requires to a fler death. Director: After this certificate has been signe ad in by the funeral director, page 2 should be e	ertiflcation:	3 Suicide 6 Could not be	28e. Place of Injury - At	home, farm, stre	et, factory, office		28f. Location (Str	eet and Number	or Rural Route Number,
Div	erti	4 Homicide	building, etc. (Spec	cify)			City or Town	, State)	
Hospit 4 hour Funere	ical (29a. Certifier 1 X Certifying Phys (Check only one)	sician: To the best of my kiner: On the basis of examinand manner stated.	nowledge, death nation and/or inv	occurred at the timestigation, in my op	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and manr ite and place, an	ner as stated. d due to the cause(s)
To the within 2 To the Complet	Me	29b. Signature and title of certifier			29c. License	e number	29	d. Date signed ((Month, Day, Year)
F ≯ F 8			1 1/1			(0007			
		30. Name and address of person who co	amietad cause of death (Its	8m 23a) (Tupe 5	Print)	60887		Octobe	er 22, 2005
					,	Cherry C	baca M-	walend '	20015-77
	State	Jack L. Flyer, M.D 31. Date filed (Month Day Year) NOV 0 8 2005	32. Registrar's Sign	nature AV	enue 1/30	onevy C	mase, Ma	ryraild ,	444/
	istrar	NOV 0 8 2005	Hand on a	Lingar					

		•	For State Registrar	State of M	laryland	•	artment of F		nd Mental Hy	giene Reg. No.	05	35982
	Physicia		1. Decedent's Name (First, Middle, L	ast) rick Getri	is				2. Date of De Month Nov • 2	Day	Year	3. Time of Death 1:10am м
	/Medic Examin	- 4	4a. Facility Name (If not institution, g				4b. City, Town, o		Death	4c. Cou	nty of Death An i	ne Arunde
	Funeral Director		344-10-5358	Sex 7. A	ge (In yrs. Ia 93	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Bin Min. (Month, Da March 1	th y, Year) 7,1912	Cou	place (State or Foreign ntry) 2890, IL
	show	J.	Usual Residence of Decedent 10a. State 10b. County MD Prince	Georges	10c. City	Town or Lo		<u> </u>				10d. Inside City Limits 1 ☑Yes 2 ☐ No
	with the M a or 28a-f be notiff	Director	10e. Street and Number 12421 Madeley				10f. Zip Code 2071	5		10g, Citizen		
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other then "naturel", or Items 23a or 28a-f show simarked other then "naturel", or Items 20a or 28a-f show eumatic event, the Marical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Never Married 4 Divorced	12. Was Deceden Armed Forces	7 No	I		lispanic Origin	? (Specify Yes or No Puerto Rican, etc.)	- 14. F	Race - Ameri Black, White,	
Maryland 21215-0036	within 72 ho iene then "nature it e mource!!	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)		5+)	(Give life. I	dent's Usual Occup kind of work done DO NOT use retired alesman	during most of	f working		f Business/Ir ric Su	·
land 2	d d d	To Be Co	17. Father's Name (First, Middle, La Anthony Getris	•	1			21	Name (First, Middle, nna	Maiden Sun	name)	
	D € ► ₩		19a. Informant's Name/Relationship Ursula Unnewehi			12	421 Made1		-	MD 207	15	
altimore,	Pa Info		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spe	cify)	, ce	metery, cren	sition (Name of natory or other place on Cemetery	ce)	11/7/05		stice,	
Ball	permit. Departm Importe eny inju		21. Signatule o Funeral Service Lic)		4	1501 Fast	Stevens Fort Ave	s Funeral Ho e Baltimore J	MD 21230)	
	Physician /Medical Examiner	ı	23a. Part1. Enter the disease, shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	ly one cause on each	line. 20 SC s a consequ 25th V	ience of):		_	Vascula Vascula (me		Pasc	Approximate Interval Between Onset and Death y Cours J-Cours
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or a								
.O. Box 6	that the death certific ted by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)	/		23d.	Date of deliv Month	ery Day Year
rds, P.	w requires that been signed t should be delt	þ	Part II. Other significant conditions	s contributing to death	but not resu	ilting in the u	nderlying cause giv	en in Part I.	23e. Did t	6540		the cause of death?
al Records,	sicien: The law requ certificate has been irector, page 2 shoul	Completed							1 Tyes	rmed? 22 No	b. Were auto prior to co death? 1 \(\subseteq \text{Yes}	opsy findings available impletion of cause of
Division of Vital	ding Phy T. After this funeral d	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigal 3 Suicide 6 Could no	ho	jury ay Year)	ER/Outpatien 28b. Time of Injury	28c. Injur Wor M 1	v at Nursi		dence 6 🗆 o	curred	
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	To the Hospital or Attent within 24 hours after deall To the Funerel Director: completely filled in by the	Medical	29a. Certifier (Check only one) 2 Medical Ex	Physician: To the bes aminer: On the basis and manner s	of examinat	ion and/or in	vestigation, in my o	pinion, death	occurred at the time,	cause(s) and date and place 29d. Date sign	ce, and due t	o the cause(s)
ł	M 7.		Kakes	houro	19	MD						mpaons
	VP		30. Name and address of person where the same and address of person address of person and address of person and address of person address of person and address of person and address of person address of pe	A PO 1	death (Item	23a) (Type, 6A)	And Fox	LANE"	Sune 27	2 B	02016	mpaoris
	Sta Registi		NOV 0 8	2005	ال معالم	8 4						

State of Maryland / Department of Health and Mental Hygien 0.535983 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** NOVEMBER 3, 2005 GARONZIK 11:35 AM ADA /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PIKESVILLE BALTIMORE NORTH OAKS HEALTH CENTER 8. Date of Birth

Month, Pay, Year)

JAN. 31, 1915 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2□F Yrs. 90 MD Director 212-28-0850 Usual Residence of Decedent e filed within 72 hours after death with the Maryland at Hygiene.

other than "natural", or frems 23a or 28a-f ehow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director PIKESVILLE BALTIMORE MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 725 MT. WILSON LANE 21208 USA Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No WHITE Specify: <u>^</u> Specify: 3 ₩ Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CHECK CASHING OWNER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 9 Pages 1 and 2 should be nent of Health and Mental sut: If item 27 is marked o BENDER GREENBERG DVORAH JOSEPH P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 STONE HOLLOW COURT - BALTIMORE, MD 21208 ROBERT GARONZIK / 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of h
important: If ite
eny injury or ot 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State BETH TFILOH CEMETERY 11/07/2005 WOODLAWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such Immediate Cause (Final ay **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 1 40 3 Ectopic pregnancy 0 Month Year Day 4☐Pregnant at time of death 5 Other (specify) PO pege 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 100 Division of Vital the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: ၉ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Anatural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after o 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) To the I within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

NOV O

State of Maryland / Department of Health and Mental Hygiehoe () () 5For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** WILLIAM H. GRIER 1. 90 bw Dellusion a005 /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number **Examiner** N/A Denera time If Under 1 fear If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 237-20-3261 89 1 ☐ M 2 💢 F Director 7-29-1916 NORTH CAROLINA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28e-1 show in then "natural", or items 23a or 28e-f show the Wedical Examinar must be nutified at 1 → Yes 2 □ No N/A Director MD. BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3809 CLARKS LANE APT 204 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 🔀 Married 1 TyYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ANo Specify: Specify: Completed by BLACK 3 Widowed 4 Divorced Maryland 21215-003 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) marked other than College (1-4or 5+) -12-ENGINEER SCHOOL traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3809 CLARKS LANE APT 204 BALTIMORE, MARYLAND 21215 LOUISE GRIER(WIFE) timore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 11-8-2005 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ☑ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or GARRISON FOREST VETERANS OWINGS MILLS, MD. 21. Signature of Funeral Service License JONATHAN D. HIBNER Name and Address of Facility REDD FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1. If ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final Physician resulting in death) /Medical Due to (or as a consequence of): Examiner uen mou Sequentially list conditions. r any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of) nding physician IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ate has been signed by the atterpage 2 should be detached for in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Ö 9☐ Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 Yes the funeral director, To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 270 No 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes this Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Medical Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospitel or 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Marylar	nd / Departme <i>Certifica</i>	ent of Health ate of Death	and Mental	Hygie		35985
6.3	Physic /Medi		1. Decedent's Name (First, Middle, Last)	HAWKINS		,	2. Date of Month	of Death	ay Year	3. Time of Death
	Exami		4a. Facility Name (If not institution, give	Squares of	A 4b. Ci	y Town, or Location Baltimor	of Death		c. County of Death	
	Funeral Director		5. Social Security Number 6. Sep 2/14-62-2023 1C Usual Residence of Decedent	7. Age (In yrs.	last birthday) If Und Yrs. Month	ler 1 Year If Under s Days Hours		of Birth Day, Sear	N A	place (State or Foreign
	e Maryland la-f ehow	ctor	10a. State 10b. Column	10c-0	ALIMOTE					10d. Inside City Limits
	ath with the 23a or 28	Funeral Director	734 Whatten	1 Ot.		21/205			itizen of What Con	intry?
920	urs after de al', or item Examiner n	by Fune	11. Marital Status 1	12. Was Decedent Ever in U Armed Forges? 1 ☐ Yes 2 If Yes, Give Year or Dates:		edent of Hispanic Or becify Cuban, Mexical 2 No Specify:		or No-	14. Race - Ameri Black, White, Specify: AL	
21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or iteme 23a or 28a-f ehow or other traumatic event, the Modical Examinar must be notified at	Completed by	15. Decedent's Edu (Specify only highest grade Elementary Secondary (0-12)	cation a completed) Cdllega (1-4or 5+)	16a. Decedent's Us (Give kind of v life, PDWOT	sual Occupation work done during mos use retired	t of working	16b	(ind o) Business/Ir	DOUED
	2 should be filled with and Mental Hygiene. Is marked other than sumatic event, Inc.	To Be Co	17 Father's Name (First, Mfödle, Last)	SON	- HOUN	16. Whithe	Pris Name (First Mi	ddle, Maiger	Sumame)	, ,
, Maryland	1 and 2 should Health and Men om 27 is marke		19a Informant's Name/Relationship	(30L)	195 Mailing Address	METEL	er or A al Rou e	umb + City	o Timi, Jate, Zi	Code LS
Baltimore,	Part Ja		20a. Method of Disposition Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	1	Imprery stematory of	other place)	11-2-05	BA	ocation ity r T	own, late
Ba	Departition of the control of the co		21. Sign time of Funeral Service License 23a. Part1. Enter the disease, or compli	Zumore	1308	and Address of Facility OF OF OF OF OF OF OF OF OF O	EATALE	BI	198 M	Approximate
	Physician /Medical		shock, or heart failure. List only or tmmediate Cause (Final disease or condition resulting in death)	e cause on each line. E N Due to (or as a conseq A slv			cardiac or respirate	ny arrest,		Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq		05				F wyn
,0928	cate be executed physician and the burial-transit	dicai Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):					
	The law requires that the death certifica te has been signed by the attending ph page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	death 3 Ectopic				23d. Date of delive Month	ery Day Year
rds, P.	w requires that been signed b should be deta	þ	Part II. Other significant conditions con	tributing to death but not resi Lemen ha	ulting in the underlying	cause given in Part I.		id tobacco i	_	he cause of death?
		Completed					a	Vas an utopsy erformed? es 2 ⊠ No	prior to co death?	psy findings available mpletion of cause of
Vita	Physician: this certificanal director, I	Be	25. Was case referred to medical examiner?				of Death Check or	nly one)		
of	Phys this al dir	2	10 163 2 10		ER/Outpatient 3 [rsing Home 5 🗆 F			(v)
	Jing After fune	Certification;	27. Manner of Death 1 Avatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Tyes 2 1		be how inju	ry occurred	
Divi	Dir		4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	"	•	City or	Town, State		
	Hospital 24 hours Funeral letely filled	edicai	(Check only 2 Medical Examin	ician: To the best of my knower: On the basis of examination and manner stated.	wiedge, death occurre tion and/or investigation	at the time, date and n, in my opinion, deat	d place, and due to th occurred at the til	the cause(s) ne, date and	and manner as si place, and due to	tated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifi v	mo	29	9c. License number D 06 6263 v	1	1	te signed (Month,	Dey, Year)
n	1		30. Name and address of person who con	mpleted cause of death (Item	23a) (Type, Print)					
r L	di con		MATRIST ALLAN		Mod) S F	ERRY RD	BALTIM	. R.=	MO 2122	7
1	Sta Registr	120	31. Date filed (Month, Day, Year)	82. Registrar's Signa	-					

			1 - For State Registrar	State of M	aryland / Depa		lealth and I		ene	35986
	Physic /Medi	cal	1. Decedent's Name (First, Middle	Hood				2. Date of Death Month	Day / Year	3. Time of Death 250 PM
	Funeral	ner	5. Social Security Number 217–36–4892	Care	e (In yrs. last birthday) Yrs.	4b. City, Town, or If Under 1 Year Months Days	Location of Death LPSUIN If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	4c. County of Death (ear) 9. Birthp Cour	lace (State or Foreign
	Director mode mode	or.	Usual Residence of Decedent 10a. State 10b. County Md Balti	77	10c. City, Town or Lo			Aug 7 193	37 Md	0d. Inside City Limits
	th with the M 23a or 28e-f	Funeral Director	10e. Street and Number 15803 Trenton F	load		10f. Zip Code 21155		10g US	i. Citizen of What Cour	1 ☐ Yes 2 No
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-f ahow empirity or other traumatic event. If a Modical Examine must be notified at ance.	b	11. Marital Status 1 ☐ Never Married 2ሺ Marri 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Amed Forces? ed 1 Tyes 2 The If Yes, Give Year or Dates:	10	Was Decedent of H. If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	ispanic Origin? (Sp n, Mexican, Puert Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Race - Americ Black, White, Specify: Whi	etc.
Maryland 21215-0036	d within 72 ho giene. er than "natu: . Ir e Medical	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 12		(Give	dent's Usual Occupa kind of work done o DO NOT use retired truck dr	during most of worl ')	king	b. Kind of Business/Inc	,
ryland	2 should be filed withir and Mental Hygiene. ia marked other than aumatic event, I''s Ma	To Be C	17. Father's Name (First, Middle, I Howard Ephria	m Hood			Olea Rur			
	os 1 and 2 shoot Health and item 27 ia n		19a. Informant's Name/Relationsh Barbara A. Hood 20a. Method of Disposition		15803	3 Trenton	Rd., Upp	perco, Md	ity or Town, State, Zip 21155 c. Location - City or To	
Baltimore,	permit, Pages Department of I Important: If its eny injury or o		1X Burial 2 Cremation 4 Donation 5 Other (Sp. 21. Signature of Funeral Service L	ecity) icensee	Prospect 22	. Name and Addres	11-8-	-05 Mt	. Airy, Md	
III NO SOURCE	/Medical Examiner	niner	23a. Part1. Enter the disease, or shock, or heart failure. List of limediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate the carbon of the cause (Disease or injury)	complications that caused nily one cause on each line. a	the death. Do not ente		g, such as cardiac			Approximate Interval Between Onset and Death Usaffa
68760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the buriat-transit	edical Examiner	that initiated events resulting in death) Last	c. Due to (or as a	a consequence of):					
.O. Box	it the death certific by the attending p tached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliver Month	ry Day Year
ords, P.	w requires that been signed b should be det	by	Part II. Other significant condition	s contributing to death bu	it not resulting in the un	derlying cause give	n in Part I.	23e. Did tobac	co use contribute to the	e cause of death?
of Vital Records,		e Completed	25. Was case referred to medical				26. Place of Death	24a. Was an autopsy performed 1 Yes 2 1	prior to com	sy findings available apletion of cause of
Division of Vi	ding Phys n. After this funeral dii	ertification; To B	examiner? 1 Yes 2 Accident investigation of the could not be a compared to the could not be a c	tion	Year) 28b. Time of Injury	3 DOA Othe 28c. Injury Work M 1 Y	r: 4 ursing Ho		e 6 □Other (Specify, njury occurred	
Divi	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	0	4 Homicide determin	28e. Place of Injubulding, etc				City or Town, S		
	To the Hos within 24 h To the Fur completely	Medical	(Check only 2 Medical E	xaminer: On the basis of and manner stat	examination and/or inv	estigation, in my opi	nion, death occurr	ed at the time, date	and place, and due to to	the cause(s)
	Ve		30. Name and address of person of	ho completed cause of de	ath (Item 23a) (Type, F	Print)	00580	37	11/7/08	
	Sta Registr		31. Date filed (Month, Bay, Year)	255 32. Polijstra	Stone/	Hue St	307 V	Vostmin	ster ME	> 21157
DHI	MH 17 Rev 1/20		NOV 0 8	2005 Blow	w to fig	339				

	ian	1. Decedent's Name (First, Middle, Las Walter Eugene H	·				2. Date of Dea Month	5, Day 2005	3. Time of Death
	ical	4a. Facility Name (If not institution, give			4h City Town or	Location of Death	Nov.	5, 2005	
Exami	ner	Millenium Health	, ·			tt City		Howard	am
unera	Г	Social Security Number 6. S	7. Age (In yrs. la:	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9 B	irthplace (State or Foreign
irecto		214 20 7037	Z ^{M 2□ F} 72	Yrs.	Months Days	Hours Will.	Jan 16,	1933	MD
Mo m		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loca	ation				10d. Inside City Limits
id other than "natural", or iteme 23a or 28e-f ehow event, the Medical Examiner must be notified at	tor	MD How	ard	C	Cooksvill	e			. 1 ☐ Yes 2 No
or 28	Director	10e. Street and Number			10f. Zip Code		1	log. Citizen of What (Country?
23a		14385 Frederick			2172			US	
Day	Funeral	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ever in U.S. Armed Forces?	. 13. W	as Decedent of His Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Arr Black, Wh	
Exam	þ.	3 ☐ Widowed 4 ☐ Divorced	1X□Yes 2□No If Yes, Give Year or Dates: Korea	1 (□Yes Ž∏ No	Specify:		Specify: B	lack
ical	Completed	15. Decedent's Ed (Specify only highest gra	ucation	16a. Decede	ent's Usual Occupa	ation	ring	16b. Kind of Busines	s/Industry
vent, the Mes	m pie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. Do	O NOT use retired))	ling		
ä		12 17. Father's Name (First, Middle, Last)	M	ilitar	y Servic		a (First Middle)	Army Maiden Sumame)	
	To Be		nder Holland, S	r.				zabeth Pov	
	-	19a. Informant's Name/Relationship (7			Address (Street a			; City or Town, State,	
		Mrs. Ida Williams	(Sister)					e, MD 2172	
		20a. Method of Disposition 1 XBurial 2 Cremation 3		ce of Disposi netery, crema	ition (Name of atory or other place	9)	Date	20c. Location - City o	r Town, State
		4 □Donation 5 □Other (Specify	Bus	hy Par	k Cemete	ry 11/1:	2/2005	Cooksville	e, MD
once.		21. Signature of Funeral Service Licen	Haist	HAT Svk	Name and Address GHT FUNE esville,	RAL HOME MD 21784	& CHAPE	L, PA (Box	195)
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the death.						Approximate Interval Between
m	100	Immediate Cause (Final disease or condition	. PROSTATE	CAI	NCER				Onset and Death
al er		resulting in death)	Due to (or as a conseque	nce of):					
	ē	Sequentially list conditions,	b. Due to (or as a conseque	nce of):					
Ī	i i	if any, teading to immediate cause. Enter Underlying Cause (Disease or injury	5 45 15 (6) 43 4 501150445	1100 01).					
	Examin	that initiated events resulting in death) Last	Due to (or as a conseque	nce of);			·		
	dlcal	(d						
	Med	IF FEMALE:							
	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnand	eath 3 □E	ctopic pregnancy			23d. Date of de Month	olivery Day Year
	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of dea 9□ Unknown	tn 5∐(Other (specify)				,
	급	Part II. Other significant conditions co	intributing to death but not resulti	ing in the und	lerlying cause give	n in Part I.	23e. Did tob	pacco use contribute t	o the cause of death?
	>						1 C V-	s 2 No 3 P	robably 4 Dunknown
	þ						I L TE	_	
	þ						24a. Was a		utopsy findings available
page 2 should be detached	þ						24a. Was a autops perform	y prior to ned? death?	completion of cause of
	Completed by	25. Was case referred to medical examiner?				26. Place of Deat	24a. Was a autops perform 1 Yes 2	y prior to death? 1 ☐ Ye	completion of cause of
	To Be Completed by	25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No	Hospital: 1		3□ DOA Other	r. 4 Nursing Ho	24a. Was al autops perform 1 Yes 2	y prior to death? 1 ☐ Ye	completion of cause of s 2□ No
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on .	To Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier Could not Pending investigation of the determined	28a. Date of Injury 2 28a. Ptace of Injury - At hombuilding, etc. (Specify) sician: To the best of my knowle	8b. Time of Injury e, farm, stree	3 DOA Other 28c. Injury Work M 1 Y	at ? es 2 □ No	24a. Was an autops perform 1 Yes 2 an Check only one 5 Reside 28d. Describe how 28f. Location (Str. City or Town and due to the cased at the time, darents performed to the cased at the time, darents performed to the cased at the time, darents performed to the cased at the time, darents performed to the cased at the time, darents performed to the cased at the time, darents performed to the cased at the time, darents performed to the cased to th	y prior to death? O No 1 Ye	completion of cause of s 2 No No No No No No No No No No No No No
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director, page 2 should be	edical Certification: To Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier Chieck of Could not be determined 29b. Signature and title of certifier	28a. Date of Injury 2 (Month, Day Year) 28e. Ptace of Injury - At hombuilding, etc. (Specify) sician: To the best of my knowle and manner stated.	8b. Time of Injury e, farm, stree edge, death on and/or inves	3 DOA Other 28c. Injury Work: M 1 Y ot, factory, office cocurred at the time stigation, in my opi	at ? es 2 □ No e, date and place, nnion, death occurr	24a. Was an autops perform 1 Yes 2 h. Check only one 5 Reside 28d. Describe ho City or Town and due to the cared at the time, da	prior to death? O	completion of cause of s 2 No No No No No No No No No No No No No

Amend itenf/3aPI 25.27,28a-f, perME, G849, 12/1705 Tr State of Maryland / Department of Health and Mental Hygiepe 05 35988 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** HARRIS 2151 atoser 30 SAMUEL 2005 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** THE JOHNS HOPKINS HOSPITAL BALTIMORE If Under 1 Year | If Under 24 H Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Days Yrs. Μ́D 62 43 Director 220-38-5470 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show ral, or items 23c or 28a-f show 1 ☐ Yes X☐ No Director Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3535 Orchard Shade Road 21133 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 【 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify 3 ☐ Widowed 4 ☐ Divorced Black "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Munical 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 5+yrs Tow Truck Driver Aarons Towing Co. 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Samuel Harris Cecelia Nichols 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21133 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is in any injury or other traum once. Carolyn Hicks-Sister 3535 Orchard Shade Rd. Randallstown, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2XX remation 3 ☐ Removal from State 11/5/05 Baltimore, Md ' 4 ☐ Donation 5 ☐ Other (Specify) Metro Creamtory Inc. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, 21215 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear thilure. List only one cause on each line. Cocaine use with complications Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Examiner certificate be executed as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. the attending physician Physician/Medical Acrest SLIEctopic pregnancy
S Other (specify) CERTIFICATION APPROVED BY MEDICAL EXAMINER FROI (Adseless Frecherad IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant The law requires that the death in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐ Pregnant at time of death detached been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 1□ Yes 2X No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ipital: 1 Inpatient 2 ER/Outpatient 3 DOA Other:

28a. Date of Injury (Month, Day Year)

28b. Time of Unix 28c. Injury at Injury Other: 4 Nursing Home 5 Residence 6 Other (Specify 9 this unk 27. Manner of Death 28d. Describe how injury occurred After t Certification: 1 ENatural 5 Pending 1 Yes 2 No investigation 2 Accident Director: 6X Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) unk 28f. Location (Street and Number, Rural Route Number, City or Town, State) 4 T Homicide within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) LEARY RES -000 MEDICAL DOCTOR CETOBER 30, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PETER (EMRY, THE JOHNS HOPFINS HOSPITAL
31. Date filed (Month, Day, Year)

32. Pegistrar's Signature 600 N. NOLFE STREET BACTIMORE, MD 21205 State NOV 0 8 2005 Registrar Catherine of

			1 - For State Registrar	State of Mar		artment of F ertificate of			giene 005	35989
	Physici /Medi		Decedent's Name (First, Middle, Last, Bernice)		Hav	nes	2. Date of Dea Month	Day Ye	ar 3. Time of Death
	Examir Funeral Director		217-20-8218	of Balt	IMOYC In yrs. last birthday Yrs.	Balt	MOY CIT	8. Date of Birth (Month, Day 04 26	4c. County of D	
	Aaryland Febow	or	Usual Residence of Decedent 10a. State 10b. County MD NA	1	Oc. City, Town or D					10d. Inside City Limits 1 ☑ Yes 2 ☑ No
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other then "naturel", or Iteme 23s or 28s-f show other treumatic event, the Modical Exeminar must be notified at	Funeral Director	10e. Street and Number 6610 Vincent La 11. Marital Status	12. Was Decedent Eve Armed Forces?	04	10f. Zip Code	215 fispanic Origin? (Sp. an, Mexican, Puerto		U . S	•
215-0036	2 hours aft naturel", or	by	1 Never Married Married Married 3 Widowed 4 Divorced 15. Decedent's Edu	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	16a. Dec	1 ☐ Yes 2 ☐XNo	Specify:		Specify:	Black
21	filed within 7 Hygiene. other then "r ent, the Med	Completed	(Specify only highest grad	College (1-4or 5+)		e kind of work done DO NOT use retired Clerk		5		ecurity Ad
Maryland	hould be fill d Mental H marked ott matic even	To Be	17. Father's Name (First, Middle, Last) James Mitchell Local Research Name (Paletises bin (Fig. 1981))	one Oriet	105 14-1		Brennie	Faulkr		
	ges 1 and 2 sho t of Health and I if item 27 le ma or other treuma		19a. Informant's Name/Relationship (T) Joseph Haynes—H 20a. Method of Disposition		6610	Vincen	t Lane a		r, City or Town, State Balto 20c. Location - City	, Md 21215
Baltimore,	t. Page rtment o rtant: If njury or		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Sign ture of Funeral Service Licens		Metro (matory or other plac	y Inc.]		Baltim	
Be	Dermi Depa Impo eny Ir		23a. Part I Enter the disease, or compl shoot, or heart failure. List only or	ications that caused the	te !	larch F/ 1300 Wab	H West ash Ave	Balti or respiratory arm	more, M	d 21215 Approximate Interval Between
>	Physician /Medical Examiner	er	Immediate Cause (Final disease or condition resulting in death)		ustalic consequence of):					Onset and Death 10 months
68760,	ficate be executed physicien end s the burial-transit	edicai Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c						
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physicien end bage 2 should be detached for use es the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 2 [4 Pregnant at tim	Fetal death 3	□Ectopic pregnancy	,		23d. Date of Month	delivery Day Year
	w requires that i been signed by should be deta	þ	Part II. Other significant conditions col			underlying cause giv	en in Part I.			e to the cause of death? Probably 4 Unknown
tal Reco		e Completed	25. Was case referred to medical				26. Place of Death		2 No 1 LY	autopsy findings available to completion of cause of ? es 2 \(\text{\$\exititt{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\
Division of Vital Records,	ding Phy n. After this funeral d	ToB	examiner?	1 Inpatient 28a. Date of Injury (Month, Day Y	2 ER/Outpatie 28b. Time Injury	of 28c. Injun Wor	er: 4 ☐ Nursing Hoi	mø 5□Røside	ence 6 Other (S	pecify)
Divis	itel or Attendi irs elter death. rel Director: A led in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28ø. Place of Injury building, etc. (Specify)			City or Town	n, State)	Rural Route Number,
	To the Hospitel or Attent within 24 hours efter deatl To the Funerel Director: completely filled in by the	Medical	one)	sician: To the best of r ner: On the basis of ex and manner stated	damination and/or in	vestigation, in my o	pinion, death occurre	ed at the time, d	ate and place, and	due to the cause(s)
	7		30. Name and address of person who co	t M	1 D	190	76	1	9d. Date signed (Mo Voicm ber	6 2005
	Sta Registr		29b. Signature and title of certifier Al · hand 30. Name and address of person who co PRANTTH 31. Date filed (Month, Day, Year) NOV 0 8 200	A NAIN 32 Registrar's	MD Signature	2401	West Be	lvedere	Baltin	LOSE MD2/2/
DH	MH 17 Day 1/0	301	NOV O C-SS	8						

DHMH 17 Rev 1/2001

Bernice Haynes

			1 - For State Registrar	State of I	Maryla	nd / Depa <i>Cei</i>	artment rtificate	t of H e <i>of L</i>	ealth ar D <i>eath</i>	nd M	ental Hy	giene Reg. No	000	5 3	35990
	Physic /Medi		1. Decedent's Name <i>(First, Middle, Last</i> Edna		ıdrick	ts					2. Date of De Month Nov 3	Day		Year	3. Time of Death 8:45 P M
	Exami		4a. Facility Name (If not institution, give 11080 Weymouth	Court #4	29		Wald	lorf	Location of I			4c. Cl	County o		
	Funeral Director		5. Social Security Number 6. Se 267 20 5940 15 Usuel Residence of Decedent	х]м 2Д.F XX	Age (In yrs	last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours	Hrs. Min.	B. Date of Bir (Month, Da Feb 19	th ay, Year) 9,192	23	9. Birthpl Coun Flor	ace (State or Foreign try) ida
	ith the Maryland or 28a-f show	Director	10a. State 10b. County Maryland Charles 10e. Street and Number			ity, Town or Lo Wa]	dorf	Code				10g. Citi	izen of W		Od. Inside City Limits 1 Yes 2 No try?
036	be filed within 72 hours after death with the Maryland thy giene. Id other then "natural", or fems 23a or 28a-f show event, I're Medical Ever in extransition political at	by Funeral Director	11. Marital Status 1 Never Married 2 Married *XXWidowed 4 Divorced	12. Was Decede Armed Force 1 Yes 24 If Yes, Giveryear or Date:	nt Ever in t	1	Vas Decede f Yes, speci	ent of His fy Cubar	panic Origin , Mexican, F Specify:	n? (Spec Puerto R	eify Yes or No lican, etc.)	_	14. Race Black Specify:	- America , White, e	an Indian,
Maryland 21215-0036	filed within 72 h Hygiene. ther then "natu int, the Medical	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12) 12	cation e <i>completed)</i> College (1-4d	or 5+)		lent's Usual kind of work DO NOT use kkeep	k done di e retired)	tion uring most o	f working	g		nd of Bus		ustry
yland	ed at a d	To Be (chant					Er	mma	First, Middle, Paul	Maiden	Sumame)	
	is 1 and 2 so if Health ar item 27 is other treu		19a. Informant's Name/Relationship (T): Paula G. Gage (20a. Method of Disposition	(Daughte	20b.		O Cou	ncil	Oak I	Driv	Route Number e, Wal	dorf	, MD	206	501
	permit. Pages Department of I Importent: If it any injury or o		1 N Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lins	_	l u	rlingto 22	n Nat	iona Address	$\stackrel{'}{1}$ Cemes of Facility $\scriptstyle m I$	eter Lee	y	Ar1 1 Ho	ingto me,I	on, V	Virginia 533 Old
	Anysician /Medical Examiner	ner	23a. Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	ine. Tue as a consec	th. Do not enter		of dying	such as car						Approximate Interval Between Onset and Death
	entricate be executed ding physicien and se as the burial-transit	/Medical Examine	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a											
	that the death certified by the attending I detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta at time of c	I death 3	Ectopic prec Other (spec					2	3d. Date Month		/ Day Year
	law requires ma as been signed 2 should be dei	by	Part II. Other significant conditions cor	tributing to death	but not res	sulting in the un	derlying cau	use giver	in Part I.	_					cause of death?
_ '	ate ha	e Completed	05.14								24a. Was autop perfor 1 Yes	sv	prid dea	re autops or to comp ath? Yes 2	sy findings available pletion of cause of No
	r this	To B	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpat 28a. Date of In (Month, D	jury	ER/Outpatient 28b. Time of Injury		Other: c. Injury a Work?	4 ☐ Nursin	ng Home	Check only of Residence of the control of the contr	ence 6		(Specify)	
Division	Dire Dire in by	il Certification;	3 Suicide 4 Homicide 4 Certifier 4 Certifying Physics		etc. (Specif	y)					City or Tow	n, State)			Route Number,
To the P	within 24 hours after or At Within 24 hours after of To the Funerel Direct completely filled in by	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier	er: On the basis and manner s	UI GAGIIIIIId	wiedge, death tion and/or inve	sugation, ir	the time n my opir License r	lion, death o	lace, and occurred	at the time, c	late and i	and mann place, and signed (/	due to th	ne cause(s)
· \			30. Name and address of person who con	mpleted cause of	death (Item	1 23a) (Type, P	rint) .	12	f 3°	57	-	1	1/4/	P) -	
,	Sta Registr		31. Date liled (Month, Day, Year)	32. Rec	trar's Signa	ture	hack	=Pl	cte	ì	\sim 0	20	06	46	

			For State	State of M	/larylan	d / Depa	rtment of F	lealth an Death	id Me		man up o	15	3599	
		. 7	State Registrainend Item 1. Decedent's Name (First, Middle	#10b-d Per	FH g	849 11	/10/05 J	Hearn	2.	Date of Deat			3. Time of Deat	th
130	Physici /Medic		Mary P Ho	KINS					N	OVEINDE	Day 4	2005	1921	M
	Examin	er	4a. Facility Name (If not institution			A + 2/	4b. City, Town, o				4c. County	of Death		
	Funeral	-5	UNIVUSITIF 5. Social Security Number	Maryland M		ast birthday)	If Under 1 Year			Date of Birth (Month, Day,		9. Birthp	lace (State or For	eian
	Director		213-58-4950	1□ M 2□F	73	Yrs.	Months Days	Hours		uq, 17	1932	Coun	yland	- 3
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					1	0d. Inside City Lin	nits
	Maryl f sho	tor		alto.		Balte							1 ☐ Yes 2 📆	
	or 28a	Funeral Director	Maryland B 10e. Street and Number	arco.		Datu	10f. Zip Code			10	Og. Citizen of	What Coun	try?	
	ath wil	ralD	2812 Michigan Av				21227				USA			
	itema itema	une	11. Marital Status	12. Was Deceder Armed Forces	s?		Vas Decedent of H Yes, specify Cuba	lispanic Origin an, Mexican, P	? (Specification Richards)	y Yes or No- an, etc.)		ck, White,		
936	urs aft	Ď	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates		1	☐Yes 2XNo	Specify:			Spacify	v: Wh	ite	
2-0	be filed within 72 hours after death with the Maryland tial Hyglene. ad other than "natural", or itema 23a or 28a-f show event, I're Modified Examirar rough be notified at	Completed	15. Decedent				ent's Usual Occup		f warking	1	6b. Kind of B	usiness/Ind	lustry	
2	han net	mple	Elementary/Secondary (0-12)	College (1-4o	r 5+)	lite. E	O NOT use retired	d)	WOIKING					
5 0	be filed v stal Hygie od other t		12 17. Father's Name (First, Middle,	Last)		Homen	aker	18. Mother's	Name (F	First, Middle, M	Own Ho			
an	should be filed withir Id Mental Hygiene. marked other than Imatic event, Italia	To Be	Joseph Harrison	n Baublitz				Mary		zabeth	Tillm	,		
ary	and Mand Mand Mand Mand Mand Mand Mand M		19a. Informant's Name/Relations			19b. Mailin	g Address (Street		r Rural R	oute Number,				
<u>``</u>	and 2 eaith m 27 her tra	- 5	Connie Stahler	Granddaugh [•]		890		Freder					, MD 210)43
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any fujury or other traumatic and Once.		20a. Method of Disposition 1 ★ Burial 2 □ Cremation		e ce	emetery, crem	sition (Name of atory or other place		Date		20c. Location			
Ħ	artmer ortant injury	h	4 ☐ Donation 5 ☐ Other (S) 21. Signlature of Funeral Service		вет		lem. Gard		1-09-	-2005	Ber Ar	I, Ma	ryrand	-
Ba	Depa Impo		Attle 1/ Wa	marten	+	Mo	Comas Fu 17 Cokes	neral E	Home,	P.A.	on Ma	rulan	J 21000	
			23a. Part1. Enter the disease, or shock, or head failure. List	complications that caus only one cause on each	ed the death							LYTON	Approximate Interval Between	
	Physician	ļ į	Immediate Cause (Final disease or condition	Myoca	udial	1 Ful	arction						Onset and Death	
	/Medical Examiner		resulting in death)		is a consequ									
*		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	is a consequ	ience of):								
ý	outed id ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	S .										
0,	cate be executed obysician and the burial-transit	I Ex	resulting in death) Last	Due to (or a	is a consequ	ience of):								
8760	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dlcal		d									·	
9 x c	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom				,			23d Dat	te of delive	D/	
. Box	death e atte	icia	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant	at time of de		Ectopic pregnancy Other (specify)			<u>.</u>			Day Year	
Division of Vital Records, P.O.	that the de ed by the detached	Phys	9 Unknown	9□ Unknown										
S,	signed be de	þ	Part II. Other significant condition	ns contributing to death	but not resu	Ilting in the un	derlying cause giv	en in Part I.		23e. Did toba			e cause of death? abiv 4 \toUnkno	
COL	w require been si should b	letec		- M					_	24a. Was an			, –	
Be	The tav	Completed							-	autopsy perform	ed?	prior to con death?	psy findings availant	of
ta		BeC	25. Was case referred to medical					26. Place of	Death (C	1 Yes 2	A	I □ Yes	2□ No	
<u>></u>	Physician: r this certificantal director.	은	examiner? 1 □ Yes 2 No	Hospital: 1 (Inpa		ER/Outpatient		4 140121	ng Home	5 🗆 Resider	nce 6 Oth	er (Specify)	
uc	ding P. Atter funera	tlon:	27. Manner of Death 1 Natural 5 Pendin 2 Accident investig		jury Day Year)	28b. Time of Injury	28c. Injun Worl	yat k? Yes 2 □ No	28d	I. Describe how	w injury occurr	ed		
/isi	Attending or death.	flca	3 ☐ Suicide 6 ☐ Could r	not be 28e. Place of I	njury - At hor	me, farm, stre	et, factory, office		28f.			er or Rurai	Route Number,	
ā	s after ef Direc ed in by	Certification;	4 Homicide Geterni	building,	etc. (Specify,)				City or Town,	State)			
	To the Hospitel or Attending Physicien: within Ed hours after death. To the fundered Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the bes	of examinati	vledge, death ion and/or inv	occurred at the tin estigation, in my o	ne, date and pi pinion, death o	lace, and	due to the car at the time, da	use(s) and ma te and piace, a	nner as stand due to	ated. the cause(s)	
	o the	Med	29b. Signature and time of certifier	and manner	stated.		29c. License	e number		29	d. Date signed	d (Month, L	Day, Year)	
	(1	/Cr	*		D10	765			Novem	ber 4	,2005	
	N		30. Name and address of person	who completed cause of	death (Item	23a) (Type, F	Print)		- 1					
	Sta	te	31. Date filed (Month, Day, Year)	JM M D	trar's Signat	ure &	ICHI GY	eenc s	>Trec	T BO	uto,	MD.	11201	
8-3	Registr	-		2005	00 D	A pa	Print) WHL GY							

			For State Registrar	State of Mar			t of H	ealth an			2005	35992
	Dhuaisi	-	1. Decedent's Name (First, Middle, La	st)					2. Date	e of Death	Day Year	3. Time of Death
	Physici /Medio Examir	cal	Clementine 4a. Facility Name (If not institution, given	Rosalind Ha	astings	4b. City,	Town, or	Location of D	Nove	ember	5, 2005 4c. County of Dea	7:45 A M
1			2923 Goat Hill	Road		Ве	1 Ai:	r			Harfo	ord
	Funeral			Sex 7. Age (I	In yrs. last birthday,	If Under Months	1 Year Days	If Under 24 Hours	Hrs. 8. Date	e of Birth nth, Day, Ye	ear) 9. Bi	rthplace (State or Foreign ountry)
	Director		Usual Residence of Decedent		85 Yrs.				Mar		1920 Mai	yland
	ith the Marylar or 28a-f show	tor	Maryland Harfor		oc. City, Town or L Bel Air							10d. Inside City Limits 1 ☐ Yes 2 No
	r 28a	lrec	10e. Street and Number			10f. Zip	Code			10g.	Citizen of What C	ountry?
	23a c	alD	2923 Goat Hill R	oad		21	015				USA	
	dea	ner	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Deced	lent of His	spanic Origin	? (Specify Yes	s or No-	14. Race - Am Black, Whi	
036	within 72 hours after death with the Maryland ene. than "natural", or tams 23a or 28a-f show na Modical Examinet must be notitled at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Midowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1□Yes		Specify:	oorio riiodri, c	7.0.7		hite
21215-0036	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: if Itam 27 is marked othar than "natur any Injury or other traumatic evant, the Modical once.	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give	dent's Usua kind of wor DO NOT us	k done d	urina most of	working	161	b. Kind of Business	/Industry
21	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, in a M.	E O	12		Radio	Insp	ecto	r		Ra	adio Man	ıfacturer
pu	be file ital Hy id othi evant	Be	17. Father's Name (First, Middle, Last)		_		18. Mother's	Name (First,		den Sumame)	
Va	should but and Ment	은	James Benjamin	Welch				Rosa	lie (unk)	Fear	
Maryland	2 sho and Is my		19a. Informant's Name/Relationship								ty or Town, State,	
	and ealth m 27		Thomas R. Hasting		The second second			e Driv			e, Florid	
ore	ges 1 t of H if Ita		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □	_	20b. Place of Dispo cemetery, cre Calvary U	matory or o	ther place		Date	200	. Location - City or	Town, State
Ë	tant:		` 4 ☐Donation 5 ☐ Other (Speci	אי	Church C	nited emete	ry	No:	v8,20	005Chu	rchville	, Maryland
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: if Itam 27 is any Injury or other tra		21. Signature of Funeral Service Lice	nsee	2	2. Name an	d Address	s of Facility	McComa:	s Fune	eral Home	, P.A.
			23a. Part 1. Enter the disease, or com	plications that caused the							ı, Maryla	na 21009 Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line. aGastro/	ntestina		,	ing		,		Interval Between Onset and Death Two weeks
	/Medical Examiner		Tosulary in doaliny	Due to (or as a c	onsequence of):			1				
Н		<u>-</u>	Sequentially list conditions, if any leading to immediate	b. — Due to (or as a c	onsequence of):							
١. ١	uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
Ó.	execu n and ial-tra	Exa	that initiated events resulting in death) Last	Due to (or as a c	onsequence of):							
760,	ate be executed hysician and the burial-transit	cal	(d								
	tificat ig ph) as th											
Вох 68	leath certific attending p	N/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		⊒Ectopic pre	agnancu				23d. Date of de	,
	ne deat the att	sicia	in the past 12 months? 1 Pyes 2 No	4 □ Pregnant at tim		Other (spe					Month	Day Year
P.O.	es that the death certific igned by the attending p be detached for use as	Physician/Med	9 Unknown									
	ires tha signed d be det	b	Part II. Other significant conditions	1 1	of resulting in the u		use give	n in Part I.	23e			the cause of death?
orc	v requi	ted	Ontotal On	official 1	omonum		Jeu.	10	-	1 🗆 Yes	2UN0 3UP	robably 4 Mnknown
Records,	e law has b	Completed							_ 24a	Was an autopsy	prior to	utopsy findings available completion of cause of
<u>=</u>	: The								1 🗆	yes 2		2 □ No
Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othor		Death (Check			
of	Phys this al dir	٦.	1 Yes 2 No 27. Manner of Death	Hospital:	2 ER/Outpatier			4 🗆 Nursm			6 □Other (Spe	cify)
u C	ling Phys	lon	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yo	ear) 28b. Time o	M Z	Bc. Injury Work	at ? es 2 □ No	28d. Des	scribe now in	njury occurred	
Division of Vital	death ctor: / y the f	Ica	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	e 00 - Di	- At home farm str			65 2 100	28f Loca	ation (Street	and Number or B	ural Route Number,
Ο̈́	al or A after I Dira	erti	4 Homicide determined	building, etc. (Specify)	oot, tadioty	, 011100			or Town, St		3741 7 10010 74311001,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certification:	29a. Certifier 1 Certifying Pt (Check only one) 1 Medical Example 1 Certifying Pt 1 Certifying	ysician: To the best of miner: On the basis of ex and manner stated	amination and/or in	n occurred a vestigation,	at the time in my opi	e, date and pl nion, death o	ace, and due ccurred at the	to the cause time, date a	e(s) and manner as and place, and due	s stated. to the cause(s)
	o the ithin o tha omple	Me	29b. Signature and title of certifier			29c	License	number		29d.	Date signed (Mont	h. Day, Year)
	- ≠ - ŏ		YouTik	Souder	no	Andrew Coloresta	133	2641		16	Pin hor	7 2005
	10		30. Name and address of person who	completed cause of deat	h (Item 23a) (Type	Print)	11/	WTZ		100	VMICK	1,2003
_	,		Keyn L Suya	ler my	754 HIC	Kory	We	Bel	Arn	71)	1014	
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 8 200	5 Registrar's	Signature	ask of						n, Day, Year) 7, 2005

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygier [] 15 35993 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death October 31, 2005 **Physician** Hall 7:30 P M Pauline Margaret /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Mariner Health of Overlea Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year May 7, 1923 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours Months 1 ☐ M 2 🖫 F May 217 16 1209 Director Maryland Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Heath and Mental Ptygiene. em 27 is marked other than "naturel", or Items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State other traumatic event, the Medical Exacultar must be notified at 1. Yes 2 No Director Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21224 502 South Eaton Street USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify. 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be Cecelia Barczykowski 2 Marion Vadorsky 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 ment of Health a ent: If Item 27 is ury or other tra Margaret A. Titus (daughter) 1509 Galena Road Baltimore, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Importent: If any Injury or once. 4 □ Donation 5 □ Other (Specify) Sacred Heart of Jesus 11/03/2005 Dundalk, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home PA ture of Pyneral 1407 Old Eastern Avenue Essex Maryland 21221 or complic tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death 23a. Part . Enter the dis sheek, or heart failu Immediate Cause (Final disease or condition resulting in death) Enter the disease or heart failure. Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequent) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IE FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. ate has been signed by the a page 2 should be detached in 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy Yes Hospitel or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Cther: 1 ☐ Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA (his After this 28c. Injury a Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Matural 5 Pending death. 1 ☐ Yes within 24 hours after death.

To the Funerel Director: completely filled in by the f 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and life of certifier D25391 11-1-05 Blud, Baltimore MD 21239 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D 5601- Loch X 31. Date filed (Month, Day, Year) State Registrar NOV 0 8 2005

DHMH 17 Rev 1/2001

CHIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 35994 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** arrel vovernie 2 2005 /Medical Facility Name (If not institution, give street and number Town, or Location of Death 4c. County of Death Examiner Social Security Number Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country). **Funeral** 1 M 2 KF Months Days Hours -50-Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits or 28a-f show traumatic event, the Madical Examiner must be notified at 1 Wes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a Funeral Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2 📉 o Specify: þ 3 Widowed Divorced "natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other than dary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should Department of Health and Men 19b. Mailing Address (Street and Number or Rural Rout Number, Important: If item 27 is any injury or other *-nod of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ture of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause or, each line. Do not enter Approximate Interval Between Onset and Death such as cardiac or respiratory Immediate Cause (Final **Physician** disease or condition resulting in death) La /Medical Due to (or at a consequence of): (me west Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transi Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Year Month Day 4 Pregnant at time of death 5 Other (specify) P.O. the detached 9☐ Unknown Š signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 4 Dunknown funeral director, page 2 should Be Completed 1 ☐ Yes 2 ☐ No 3 Probably peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy performe 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 인 1 🗌 Yes 1 Innatient 2 ER/Outpatient his 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Alter Certification: 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No investigation after death 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Thomicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29d. Date signed (Month, Day, Yea 29b. Signature and title of certifier 29c. License number 3066 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) reamen 32. Strar's Signature State Registrar NOV 0 8

			1- State of Ma	aryland / Depa <i>Cer</i>	artment of Health a tificate of Death	nd Mental Hygie		35995
			Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physici /Medic		RALPH DEWIT	T IG	LEHART	Month NOVEMBET	Day Year	5 2:15 AM
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of		4c. County of Dea	
			OAK CREST VILLAGE		PARKVILLE	5	BALTE	. CO.
	Funeral		150	e (In yrs. last birthday)	If Under 1 Year If Under 2 Months Days Hours	4 Hrs. 8. Date of Birth (Month, Day, Y	ear) _ C	thplace (State or Foreign ountry)
	Director		217 - 03 - 0556 19m 20F	94 Yrs.		JAN 7	1911 MI	ARYLAND
/and	Mo to		10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
Мал	F Sh	to	MD. BALTIMORE	PARKUI	UE			1 ☐ Yes 2 PNo
th the	s 23a or 28e-f show wsi be mulified at	Director	10e. Street and Number APT	3215	10f. Zip Code	10g	. Citizen of What Co	ountry?
th W	23a (a	8832 WALTHER BLUI	- 4 -	21234		U.S	. A .
3-0030 72 hours after death with the Maryland	"natural", or Items 23a polical Exerciper: sust t	Funeral	11. Marital Status 12. Was Decedent Armed Forces?	li li	Vas Decedent of Hispanic Orig Yes, specify Cuban, Mexican,	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ame Black, Whi	
s afte	0	by Fi	1 Never Married 2 Married 1 Per 2 If Yes, Give 3 Widowed 4 Divorced Year or Dates:	1	☐ Yes 2 No Specify:		Specify: W	,
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2 sh	is m		19a. Informant's Name/Relationship (Type, Print)		g Address (Street and Number			Zip Code) 21210
6, 5	Health em 27 ther t		PHYLLIS ROSS, REPRESE	20h Place of Dispos	NOLL RIDGE	CT APT /	931 BAL c. Location - City or	TO MD.
	Department of Health and Men Important: If item 27 is marke any injury or other traumatic pnca.		1 2 Burial 2 Cremation 3 Removal from State		sition (Name of patory or other place)		•	
Daltimo Dermit. Pages	Department of Important: If any injury or ance.	. 1	' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	PRUID RI	DGE CEMETERY Name and Address of Facility	11-4-03	ALTIMO	RE MD.
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			23a. Part1. Enter the disease of complications that caused shock, or heart failure. List only one cause on each line.	the death. Do not ente	or the mode of dying, such as o	ardiac or respiratory arrest		Approximate
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9 P. C.	h. After this certificate hi funeral director, page	n: T	27. Manner of Death 28a. Date of Injur	The second second	28c. Injury at Work?	28d. Describe how i		ony)
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or Att	fter de Nrect n by t	ertification;	3 Suicide 6 Could not be determined 28e. Place of Injudent Description	ury · At home, farm, stre c. (Specify)	et, factory, office	28f. Location (Stree City or Town, S	t and Number or Ru tate)	ural Route Number,
Pital C	erel D	O	29a. Certifier Certifying Physician: To the best					
To the Hospital or Attending Physicien: The law requires that the death certif	within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	edical	29a. Certifier (Check only one) Certifying Physician: To the best of Medical Examiner: On the basis of and manner sta	examination and/or inv	occurred at the time, date and estigation, in my opinion, death	place, and due to the caus occurred at the time, date	a(s) and manner as and place, and due	s stated. to the cause(s)
To th	withir To th comp	Me	29b. Signature and title of certifier Mo		29c. License number	29d.	Date signed (Monta	h, Day, Year)
					D13112	N	twent 1	11 2005
	10		30. Name and address of person who completed cause of d	eath (Item 23a) (Type, F	Print) Pertil	le mo :	21277	
1	Sta	. 0	31. Date filed (Month, Day, Year) 32. Pagištra	ar's Signature		- 11.00	-1-11-	
	Registr	ar	NOV 0 8 2005	w Dr. Ag	ere)			

DHMH 17 Rev 1/2001

ICIEHART, RalPH

	•	1 - State Amend Ite	State of Maryland m #7 Per FH G	849CLH/	84.0 501 D eath		Reg. No.	105 3	35996
Physici /Medi		1. Decedent's Name (First, Middle, Last) WILLIE	JAN	11504	, IR.	2. Date of Do Month	Day	, 2005	3. Time of Death 10: 40 PM
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hours after	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Yes 2 No Specify:				ack
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		shock, or heart failure List only or	ications that caused the death	n. Do not enter the	e mode of dying, such as care				Approximate
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or Attending Physician: The law requires that the differ death. Director: After this certificate has been signed by the in by the funeral director, page 2 should be detached.	edical Certification; To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1	1 Live birth 2 Fetel 4 Pregnant at time of de 9 Unknown htributing to death but not result 28a. Date of Injury (Month, Day Year) 28b. Place of Injury - At hobuilding, etc. (Specify sician: To the best of my knowner: On the basis of examinat	ER/Outpatient 3 28b. Time of Injury when, farm, street, five whedge, death occition and/or investign.	ying cause given in Part I. 26. Place of DOA Other: 4 \(\) Nursin 28c. Injury at Work? 1 \(\) Yes 2 \(\) No factory, office	24a. Was perful yes Death (Check only g Home 5 Res 28d. Describe 28f. Location (City or To ace, and due to the courred at the time,	Yes 2 \(\text{Yes} 2 \) \(\text{In an psy ormed?} \) \(\text{Yes one)} \(\text{In an psy ormed?} \) \(\text{Yes one)} \(\text{In an psy ormed?} \) \(\text{Yes one)} \(\text{In an psy ormed?} \) \(\text{Yes one)} \(\text{In an psy ormed?} \) \(\text{Yes one)} \(\text{In an psy ormed?} \) \(\text{Yes ormed?} \) \(\text{Yes ormed?} \) \(\text{In an psy ormed?} \) \(\text{Yes ormed?} \) \(\text{Yes ormed?} \) \(\text{In an psy ormed?} \) \(\text{Yes ormed?} \) \(\text{Yes ormed?} \) \(\text{In an psy ormed?} \) \(\text{Yes ormed?} \) \(\text{Yes ormed?} \) \(\text{In an psy ormed?} \) \(\text{Yes ormed?} \) \(\text{Yes ormed?} \) \(\text{In an psy ormed?} \) \(\text{Yes ormed?} \) \(\text{Yes ormed?} \) \(\text{In an psy ormed?} \) \(\text{Yes ormed?} \) \(\text{In an psy ormed?} \) \(\text{Yes ormed?} \) \(\text{In an an psy ormed?} \) \(\text{Yes ormed?} \) \(\text{In an an psy ormed?} \) \(\text{Yes ormed?} \) \(\text{In an an psy ormed?}	Month e contribute to the No 3 Proba 24b. Were autop prior to com death? 1 Yes: Other (Specify, occurred Number or Rural and manner as stalace, and due to signed (Month, D	Day Year o cause of death? bly 4 Innknown sy findings available pletion of cause of 2 No Route Number, ted. the cause(s)

State of Maryland / Department of Health and Mental Hygiere 0 0 5 35997 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 07 PM James Louis January , Sr. 05 2005 i F /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number, Examiner Samovitan Hos pital Baltimore Baltimore (5000) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Yeer) March 21,1945 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 2 F Months 60 Maryland Director 218-42-7185 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a State or 28a-f show the Medical Examiner must be notified at 1 Yes 2 700 Director Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 263 Nanticoke Road 21221 "neturel", or Itams 23a U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2000 No 1 Never Married 2000 Married Maryland 21215-0036 1 ☐ Yes 🗷 XNo Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 le marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Security Officer Hospital traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John January Dorothy Furlong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2:1
Department of Health ar Important: If them 27 leeny injury or other trau 263 Nanticoke Road, Baltimore, Maryland 21221 Cheryl January (Wife) Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2XDCremation 3 ☐ Removal from State Bayview Crematory, Inc. Nov 11, 2005 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 21. Signature of Fuheral Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 Approximate Interval Between Onset and Death 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Runal **Physician** Haute disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Se PSIS Sequentially list conditions Due to or as a consequence of): Examiner as the leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Preumo or Attending Physician: The law requires that the death certificate be executed use as the burial-tran attending physicien and resulting in death) Last Due to (or as a consequence of): Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐ No Division of Vital Records, P.O. 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy performed 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Beath 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending Injury after death.
Director: Af 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours Medical 1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 101 M. D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 IM DEED U. HINGORANI LOCH RAVEN BALTIMORE, MD -21239. BLVD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 8 2005 Spark Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Martha E. Johnson October 2005 6:30A /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Glen Burnie Health & Rehab Glen Burnie Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Days) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F 218-30-5755 87 Yrs. Director Oct 1918 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene.
ant: If item 27 is marked other than "neturel", or Items 23a or 28e-1 show ury or other traumatic event, I'm Medical Evaminar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Severna Park Director 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 105 Dennis Rd. 21146 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☐XNo Be Completed by Specify: Black 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Anne Arundel Elementary/Secondary (0-12) College (1-4or 5+) 6th 0 Custodian Community College Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas Wallace Maggie Moreland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Agnes Coates (Daughter) 111 Dennis Rd. Severna Park, Md. 21146 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of AS THE CONTROL OF THE CONTROL O 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or 1 4 ☐ Donation 5 ☐ Other (Specify) Church Cemetery 11-1-05 Severna Park, Md. 21. Signature of Funeral Service Licensee wm. Reese & Sons Mortuary, P.A. Larry D. Reese MC0 483 821 West St. Annapolis, Md. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) MYOCA Pnysician /Medical s a consequence of) Examiner ONAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4☐Pregnant at time of death Month Year 5 Other (specify) 9 Unknown Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 3 Probably 4 Unknown OLD CEREBROYASCULAR 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: 25. Was case referred medical examiner? Be 26. Place of Beath (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes Certification: To 27. Mann of Death 1 Natural 28a. Date of Injury (Month, Day Year) after death.
I Director: After to din by the funera 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending 2 Accident investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 1 5910-A drson who compressed faulse (regarth (flem 2)(a) (Type Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 0 5 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October ^D28 2005 Benjamin R. Johnson 0403 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 □ F 220-30-6755 69Yrs. Director 9 1936 Maryland Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Exact mer must be notified at Director Maryland Anne Arundel Lothian 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5 844 Hourglass Lane 20711 USA items 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel', or lien eny injury or other traumatic event, The Medical English 1 Never Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired, Automotive
Maintenance Forman 16b. Kind of Business/Industry Prince George's Co Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Board Of Education 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harrison Johnson Florence Belt 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol E. Johnson(Wife) 844 Hourglass Lane Lothian, Md. 20711 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cem 11-3-05 Clinton, Md. `4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Wm. Reese & Sons Mortuary Lan 821 West St. Annapolis, 100 Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due (or as a consequence of): Examiner Sequential y list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and the burial-transit be executed Due to (or as a consequence of): Box 68760. Physician/Medical The law requires that the death certificate as IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.0. the 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 ☐ Yes 2.2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate Division of Vital 1 Yes 2□ No 1 ☐ Yes ≥2 ☐ No Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 12 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Hospital or Attending Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 24 hours af 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 05 Q who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Olexe Stephun 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 0 8 2005 Registrar

State of Maryland / Department of Health and Mental Hygieze 0 0 5 36000 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOVEMBER 4, Physician 1:50p M MARJORIE GASKINS JAMES /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE 1934 WALBROOK AVE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min 8. Date of Birth (Month, Day, Year, 6-22-1907 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ ▼F VIRGINIA 98 216-10-6362 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State item 27 ia marked other than "natural", or items 23s or 28a-f show other traumatic event, Ite Medical Examinat must be notified at 1 X Yes 2 No Director MD. N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1934 WALBROOK AVE. 21217 USA Be Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) -0-Elementary/Secondary (0-12) HOUSEKEEPING DOMESTIC 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) nd Mental I Pages 1 and 2 should be ANNIE HOLLINS THOMAS GASKINS 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22408 and l 19a. Informant's Name/Relationship (Type, Print) Health tem 27 i 3614 LANCASTER RING RD. FREDERICKSBURG, VIRGINIA ALFONZO GROSS (NEPHEW) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition o <u>=</u> 1X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or 11-10-2005 LAUREL, MARYLAND MARYLAND NATIONAL 5 Other (Specify) ⁴ 4 □ Donation JONATHAN D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. uneral Service Licensee Duce 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 ter the disease, or complications that caused the death. heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examine death certificate be executed Due to (or as a consequence burial attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.0. signed by the a Id be detached f 9□ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 Probably 4 Unknown 1 ☐ Yes 2 ♠No Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has b page 2 s autopsy performed 1 Yes 2 No certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 2 No 5 Residence 6 Other (Specify) 1 Tyes 2 lhis. funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of After t Certification: Hospital or Attending 1 Natural 5 Pending investigation 1 Yes 2 No death. 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by after 4 🗌 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only one) 29c. License number 29b. Signature and title of certifier - 2005 S dress of person who completed cause of death (Item 23a) Type, Print) KUBA MU. 2 31. Date filed (Month, Day, Year) 32. Paistrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL